# LONG TERM CARE FACILITY
# RESIDENT ASSESSMENT INSTRUMENT (RAI)
# USER'S MANUAL

For Use With Version 2.0 of the

Health Care Financing Administration's

Minimum Data Set,
Resident Assessment Protocols, and
Utilization Guidelines

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*The Long Term Care Facility Resident Assessment Instrument User's Manual* **for Version 2.0 is published by the Health Care Financing Administration (HCFA) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term. care facilities.**

**This manual is intended to replace HCFA's original *RAI Training Manual and Reference Guide,* published December 1990.**

**Authors of this *User's Manual* include John N. Morris, Katharine Murphy, Sue Nonemaker, Gloria Smit, Allan Stegemann, Janne Swearengen, and David Zimmerman.**

**In addition to John N. Morris, Katharine Murphy, and Sue Nonemaker, other authors of HCFA's 1990 Training Manual are Catherine Hawes, Charles Phillips, Brant Fries, and Vincent Mor. These individuals also contributed to Chapter 3 of the *Version 2.0 Users Manual.***

## HCFA ACKNOWLEDGEMENT

The RAI Version 2.0 and related training materials were developed under a HCFA contract with the Hebrew Rehabilitation Center for Aged (HRCA). John N. Morris and Katharine Murphy, key members of the original RAI design team, had primary responsibility for developing 2.0 and participated in the development of training materials.. They 'were assisted on tasks related to 2.0 by Steven Littlehale, Jon Wolf, Yvonne Anderson, Romanna Michajliw, Wee Lock Ooi, David Levine, and other members of HRCA research and clinical staff. Staff at the Health Insights Research Group (HIRG), including Allan Stegemann, Gloria Smit, Janne Swearengen, and David Zimmerman, also participated in the development of materials for this User's *Manual* and had lead responsibility for its production. Sue Frey, Kris Engbring, Patti Beutel, and Mary Ann Sveum contributed to the final production of this *Manual.*

We also acknowledge the continued thoughtful input into version 2.0 by the principal investigators on the original design team, specifically Catherine Hawes, Charles Phillips, Brant Fries, and Vince Mor. Members of the international community using the MDS also contributed to the development of version 2.0 through their *interRAI* association.

We particularly appreciate the continued involvement and support of the countless professional associations and clinical experts that have been involved in the resident assessment initiative since its onset. They are too numerous to name individually, but special mention must be made of the contributions of individuals representing the key associations with which we have worked on nursing home reform issues: Marcia Richards, American Health Care Association; Ewie Munley, American Association of Homes and Services for *the* Aging; and Sarah Burger, National Citizens' Coalition for Nursing Home Reform.

State and HCFA Regional office personnel have played a key role in working with nursing home staff to implement the RAI. Specifically, we acknowledge the exceptional contributions of Marlene Black (Washington State), Ruth Jacobs-Jackson (California), Sheree Zbylot (Mississippi), Pat Maben (Kansas), Ellen Mullins (Alabama), Diane Carter (Colorado), and Pat Bendert (HCFA Region IV - Atlanta), all of whom have contributed their own time to serve on workgroups or develop training materials. Betty Cornelius, HCFA Project Officer and staff from her Nursing Home Case-Mix and Quality Demonstration States, have also contributed freely. We particularly appreciate the suggestions of Bob Godbout (Texas), Peter Arbuthnot (Mississippi), and Dave Wilcox (New York) in modifying the MDS 2.0 to make it more computer "friendly."

## HCFA ACKNOWLEDGEMENT
## (Continued)

Lastly, this‘work would not have been possible without the continued support of management within the Health Standards and Quality Bureau at HCFA.. Most specifically, Helene Fredeking, Director of the Division of Long Term Care Services, has played a key substantive role, as well as garnered necessary resources to support work on this initiative. Katie Phillips has worked closely with the States and Regions on RAI issues for the past several years, and has been deeply involved in developing both the State Operations Manual and pending fmal regulations on resident assessment. Finally, a major contribution to the original RAI development effort, the revisions associated with version 2.0, and the development of training materials for both versions was made by Sue Nonemaker, HCFA Project Officer for both initiatives. She also provided the HCFA leadership and coordination necessary to implement the RAI nationally.

## IF YOU HAVE QUESTIONS RELATED TO RESIDENT ASSESSMENT

Questions related to the RAI should be referred initially to the State (see Appendix A for a list of contact persons, addresses, and phone numbers.) HCFA Regional office RAI coordinators are also listed in Appendix A.

Questions that cannot be resolved at the State level or suggestions for improving this ***User's Manual*** should be referred to:

MDS **Coordiitor**
Center on Long Term Care
Health Standards and Quality Bureau
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 212441850

# PREFACE'

The nursing home reform law of OBRA '87 provided an opportunity to ensure good clinical practice by creating a regulatory framework that recognized the importance of comprehensive assessment as the foundation for planning and delivering care to this country's nursing home residents. The Resident Assessment Instrument (RAI) requirements can be viewed as empowering to clinicians in that they provide regulatory support for good clinical practice. The RAI is simply, a standardiid, new approach for doing what clinicians have always been doing, or should have been doing, related to assessing, planning and providing individualized care. HCFA's efforts in developing the RAI and associated policies, therefore, have always been centered on the premise "What is the right thing to do in terms of good clinical practice, and for all nursing home residents? "

This same. philosophy has been shared by the other members of the original design team, and the countless individuals representing associations and State governments with which we have worked in partnership in implementing the RAI nationally. I believe that it is this emphasis on interweaving tenets of good clinical practice within a regulatory model, more than any other factor, that has contributed to our successful implementation of the RAI nationally, and more importantly, the successful use of the RAI by individual nursing homes to provide quality care to their residents.

In introducing version 2.0 of the RAI, it is important to note that we always intended that the RAI would be a dynamic tool. In essence, we recognized that we could not simply publish the MDS and RAPs in 1990 and expect that they could serve as a foundation for the delivery of long term care services without ongoing evaluation and refinement over time. Consequently, with the designation of the original version of the RAI, HCFA made a commitment to the providers and consumers of nursing home services that we would sponsor the continued refinement of the RAI. While change is always difficult, this work is necessary in order for the RAI to incorporate state-of-the-art changes in clinical practice and assessment methodologies, as well as accommodate the changing needs of the nursing home population.

HCFA began an open and very collaborative process to develop version 2.0 of the RAI in early 1993 by requesting comments on the original version through a notice of proposed rulemaking published in the Federal Register. Working in concert with key members of the original RAI development team, John N. Morris, Ph.D., and Katharine Murphy, R.N., M.S., at Hebrew Rehabilitation Center for Aged in Boston, HCFA then began the arduous task of consulting with nursing home staff, State agencies, and national organizations representing the industry, consumers, and professional disciplines. We produced a series of draft documents, and continued our refinements based on comments 'from individuals and organizations with years of experience in using the original RAI. We made many substantive changes based on the comments of nursing home staff participating in a field test of the new MDS, which focused on ensuring the clinical utility and inter-rater reliability of new MDS items. We also consulted with a number of States and organizations with experience in automating the MDS, in order to make version 2.0 more computer - "friendly. "

There were a number of "guiding principles" we used in developing version 2.0 that give insight into the programmatic goals and priorities that shaped the new instrument:

- In keeping with the clinical focus used to design the original MDS, we made only those additions or changes that nursing home staff viewed as providing useful information for care planning. Our primary rule of thumb in deciding whether to add or change an item was "Is this something that clinicians need to know in order to provide care for a nursing home resident?" We also strove to keep this a minimum data set. As we waded through. an innumerable number of excellent suggestions for additional items, we would ask ourselves whether the item provided vital information or would simply be "nice to know," and whether it was something that was necessary to know for all nursing home residents. This was truly a difficult task and will no doubt result in several unhappy individuals whose suggestions did not 'survive such scrutiny. As such, the MDS version 2.0 remains a symbol of compromise-probably less information than we might like to have, but clearly an improvement as evidenced by the positive responses of facility staff participating in our field test and the positive comments received from States and associations.

- We also recognized the increasing purposes for which MDS data is being used by both nursing home staff and States. Provided that items met the primary test of supplying necessary information for clinical staff, we chose to add some items that would also support programmatic needs, such as for payment and quality improvement systems. To the extent that such programs could be supported by the clinical information obtained from the MDS, it was felt that this would minimize burden on facilities by reducing the need to report duplicative sets of information. Consequently, in response to the increasing number of States that have already implemented or expressed an interest in using MDS data for a Medicaid case-mix reimbursement system, we added those items necessary to calculate Resource Utilization Groups III (RUGs-III). RUGs-III is the payment classification system that was developed for the HCFA sponsored "Nursing Home Case-Mix and Quality" Demonstration. It has already been implemented as the basis for Medicaid payment by the four States participating in the Demonstration, with plans for six States to move to RUGs-III driven payment for Medicare in participating facilities. Designing version 2.0 to support case-mix reimbursement systems required the addition of several items from the tool known as the MDS+, which has been used in ten States for Medicaid payment. This was not in oppositionto our primary rule of "clinical utility," however, as many of the MDS + items addressed clinical "holes" in the original MDS (e.g., issues related to restorative nursing care, therapies, skin care, etc.). The incorporation of all "payment" items into the core MDS eliminates the need for States to implement alternate instruments to support payment systems, unless additional items are needed for State-specific payment systems.

- In keeping with the goal of HCFA's Health Standards and Quality Bureau (HSQB) to move forward with an MDS-driven quality monitoring and improvement system, we have also added those MDS + items necessary to generate many of the Quality Indicators (QI's), as developed by the University of Wisconsin under the auspices of the aforementioned Demonstration. This required the addition of a few items to the core MDS. More significantly, this programmatic goal underscores the importance of the quarterly review,

as more information, submitted more frequently, will be required to support our future quality monitoring systems. However, it should also be stressed that no items were added to the quarterly review. requirement solely to provide QI data. There was significant agreement within the associations and States with which we consulted that the original quarterly review requirement did not provide facilities with all items necessary to adequately monitor residents' status. In this regard, we also had to compromise and could not accommodate all of the good suggestions we received for adding items to the quarterly review requirement.

You will notice a number of changes in the new MDS, which are highlighted below:

- The sections have been reordered (e.g., ADLs are now found in Section G). All State RAIs will now have one consistent ordering of sections, with any additional State specific items found in Section S. Sections T and U have been developed for use in States participating in the Medicare Nursing Home Case-Mix and Quality Demonstration, and are not a part of the core MDS.

- A number of items and sections have been constructed to facilitate computerization and data entry. There are also new forms designed for this purpose: Basic Assessment Tracking Form, Section AA - Identification Information, which has all key information needed to track residents in data systems; and forms for tracking residents on discharge and reentry into the facility.

- Several new scales have been added to help clinicians better understand a resident's status in a number of areas. For example, there are now scales that measure the alterability and frequency of behavioral symptoms and the frequency and intensity of pain.

- Several items have been added in response to the changing needs of the nursing home population. For example, the increase in subacute, hospice, and short-term stay populations led to the inclusion of items assessing pain, discharge potential, restorative and rehabilitation needs, and infections.

Version 2.0 brings an attempt to streamline the RAP triggers. Analyses of large data sets were conducted to improve the predictive power of the triggers. In more simple terms, which triggers contributed most significantly to the identification of problems warranting care plans? Which trigger items could be eliminated? Along with reducing the number of trigger items overall, we also eliinated the distinction between automatic and potential triggers.

There have also been a number of changes in the RAI utilization guidelines, which is a regulatory term for our instructions on how the instrument must be used. For example, we created a new definition of significant change and modified our guidance on when a significant change reassessment is required, decreased the time for retention of RAI records, and changed the procedures by which errors may be corrected.

We expect the changes within version 2.0 and our policies regarding its use to be only the beginning of our commitment to improving the instrument and facilities' ability to use it

effectively. Over the next few months, we will begin a process to review and revise the existing RAPs, as well as to develop new RAPs to address areas of significant clinical importance. We also expect to conduct an ongoing assessment of training needs and to intensify our efforts to produce educational materials for both nursing home staff and surveyors. Over the next few years, we expect to revise all of the RAPs, as well as begin work on the next version of the MDS. We welcome your suggestions on all of these areas and invite you to Consider volunteering to participate in developing or reviewing materials in your own area of clinical expertise.

Finally, we thank you for all of your hard work in implementing the RAI and using it to provide quality care to nursing home residents throughout the nation.

Sue Nonemaker, R.N., M.S.
RAI Project Officer
Health Standards and Quality Bureau
Health Care Financing Administration
September 4, 1995

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# CHAPTER 1: OVERVIEW OFTHERAI

## 1.1 Overview of RAI Components

Providing care to residents of long term care facilities is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information on a resident's strengths and needs which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI helps facility staff to look at residents holistically — as individuals for whom quality of life and quality of care are mutually 'significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

Persons generally enter a nursing facility due to functional status problems caused by physical deterioration, cognitive decline, or other related factors. The ability to manage independently has been liited to the extent that assistance or medical treatment is needed for residents to function or to live safely from day to day. All necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long stay residents, as well as the resident in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are-generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, standardized approach for applying a problem identification process in long term care facilities. **The RAI should not, nor was it ever meant to be an additional burden for nursing facility staff.**

All good problem identification models have similar steps:

a.) **Assessment -** Taking stock of all observations, information and knowledge about a resident; understanding the resident's liiitations and strengths; finding out who the resident is.

**b.) Decision-making -** Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "what.9 and "whys" of resident problems.

c.) Care Planning - Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

d.) Implementation - Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" 'and "when" of resident care.

e.) Evaluation - Critically reviewing care plan goals, interventions and implementation'in terms of achieved resident outcomes and assessing the need to modify the care. plan (i.e., change interventions) to adjust to changes in the resident's status, either improvement or decline.

This is how the problem identification process would look as a pathway. 'This manual will feature this pathway throughout and will highlight the point in the pathway that each chapter discusses.


If you look at the RAI system as solution oriented and dynamic, it becomes a richly practical means of helping facility staff to gather and analyze information in order to improve a resident's quality of care and quality of life. In an already overburdened structure, the RAI offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem solving model but also because staff; across all shifts, are involved in its 'hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

Over the course of the years since the RAI has been implemented, facilities who have applied the RAI in the manner we have discussed have discovered that it works in the following ways:

Residents respond to individualized care. While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, liied with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or'deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

Staff communication has become more effective. When staff are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the RAPs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

Resident and family involvement in care has increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff have a much better picture of the resident, and residents 'and. families have a better understanding of the goals and processes of care.

Documentation has become clearer. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records find that information documented about a resident is clearer and tracking care and outcomes is more easily accomplished.

It is the intent of this manual to 'offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the RAI ensures standardii communication both within the facility and between facilities (e.g., other long term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

The RAI consists of three basic components; the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and Utiliition Guidelines specified in State Operations Manual (SOM) Transmittal #272. All components are discussed in detail in this manual.

Utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum** Data Set **(MDS).** A core set of screening; clinical and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. A **copy of the MDS** Version 2.0 can he **found at the end of this chapter, beginning on page l-6 and Appendix B.**

- **Resident Assessment Protocols (RAPs).** A component of the utilization guidelines, the **RAPs** are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. **RAPs** help identify social, medical and psychological problems and form the basis for individualized care planning.

- Utilization Guidelines. Instructions concerning when and how to use the **RAI.**

## 1.2 Overview of RAI Version 2.0 User's Manual

The manual layout is as follows:

**Chapter 1 -** Overview **of the RAI**

**Chapter 2 - Using the RAI: Statutory and Regulatory Requirements and Suggestions for Integration in Clinical Practice**

**Chapter 3 - Completing the MDS: Item by Item Definitions and Instructions**

**Chapter 4 - Procedures for Completing the Resident Assessment Protocols (RAPs)**

**Chapter 5 - Liig Assessment to Individualized Care Plans**

APPENDICES

**Appendix A: State Agencies Responsible for Answering RAI Questions**

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## 1.3 Suggestions for the Use of This Manual

This manual is designed to meet the needs of facility staff who are both skilled in the use of the RAI and staff who are just beginning to work with it.

For those who have had experience with the RAI, this manual will show you "what's new" about the RAI Version 2.0 and serve as a reference. While the MDS has change& the process of completion and application has not. You will find the item by item section informative with respect to new items and items that have been refined or expanded. You will also find that the case studies and examples provide direction regarding "how to" complete the RAP review process and what kind of documentation is required.

If you are new to the RAI and its process, you will find' this manual an invaluable companion. The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

**A.** The resident is an individual with strengths, as well as functional limitations and health problems.

B. Possible causes for each problem area and guidance for further assessment and resolution or intervention are presented in the RAPs.

**C.** An interdisciplinary approach. to resident care is vital — both in assessment and in developing the resident's care plan.

**D.** Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that are based on specific, individual characteristics.

**ERRATA SHEET FOR MINIMUM DATA SET (MDS) —— VERSION 2.0**

**SECTION AA. IDENTIFICATION INFORMATION**

**ITEM AA8b.** Special codes for use with supplemental **assessment types in Case Mix demonstration** states or other sates where **required**

b. Codes for assessments **required for Medicare PPS** or the State

Should read:
1. Medicare 5 day assessment
2. **Medicare 30 day assessment**
3. **Medicare 60 day** assessment
4. Medicare 90 day assessment
5. Medicare **readmission/return assessment**
6. Other state **required assessment**
7. Medicare 14dayassessment
8. Other Medicare required assessment

**SECTION T. SUPPLEMENT — CASE MIX DEMO. SECTING HEADING HAS BEEN CHANGED TO:**
**THERAPYSUPPLEMENT FOR MEDICARE PPS**

**ITEM T1. Instruction in bold italics between items a and b should read:** Skip **unless** this **is** a Medicare **5** day or **Medicare readmission/return** assessment.

**RUG-III QUARTERLY (10/18/94h) & RUG-III QUARTERLY (1997 Update)**

**ITEM A4a:** Date of **Readmission**

Change to: **Date of Reentry and change instruction** to: Date of **reentry** from **most** recent **temporary discharge to** a hospital in last 90 **days** (or since last **assessment or admission if less than 90 days).**

Numeric Identifier _____

# MINIMUM DATA SET (MDS) — *VERSION 2.0*

## FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### *BASIC ASSESSMENT TRACKING FORM*

## SECTION AA. IDENTIFICATION INFORMATION

| | | |
|---|---|---|
| 1. | RESIDENT NAME* | a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) |
| 2. | GENDER* | 1. Male 2. Female |
| 3. | BIRTHDATE* | Month — Day — Year |
| 4. | RACE/* ETHNICITY | 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin |
| 5. | SOCIAL SECURITY* AND MEDICARE NUMBERS* (C in 1st box if non med. no.) | a. Social Security Number<br>b. Medicare number (or comparable railroad insurance number) |
| 6. | FACILITY PROVIDER NO.* | a. State No.<br>b. Federal No. |
| 7. | MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]* | |
| 8. | REASONS FOR ASSESSMENT | [Note—Other codes do not apply to this form]<br>a. Primary reason for assessment<br>1. Admission assessment (required by day 14)<br>2. Annual assessment<br>3. Significant change in status assessment<br>4. Significant correction of prior full assessment<br>5. Quarterly review assessment<br>10. Significant correction of prior quarterly assessment<br>0. *NONE OF ABOVE*<br>b. *Codes for assessments required for Medicare PPS or the State*<br>*1. Medicare 5 day assessment*<br>*2. Medicare 30 day assessment*<br>*3. Medicare 60 day assessment*<br>*4. Medicare 90 day assessment*<br>*5. Medicare readmission/return assessment*<br>*6. Other state required assessment*<br>*7. Medicare 14 day assessment*<br>*8. Other Medicare required assessment* |

9. SIGNATURES OF PERSONS COMPLETING THESE ITEMS:

| | | |
|---|---|---|
| a. Signatures | Title | Date |
| b. | | Date |

**GENERAL INSTRUCTIONS**

***Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)***

* = Key items for computerized resident tracking

Resident _____ Numeric Identifier _____

# MINIMUM DATA SET (MDS) — *VERSION 2.0*

## FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### *BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION*

## SECTION AB. DEMOGRAPHIC INFORMATION

**1. DATE OF ENTRY** — *Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date*

Month ___ Day ___ Year ___

**2. ADMITTED FROM (AT ENTRY)**
1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

**3. LIVED ALONE (PRIOR TO ENTRY)**
0. No
1. Yes
2. In other facility

**4. ZIP CODE OF PRIOR PRIMARY RESIDENCE**

**5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY** — *(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)*

| | |
|---|---|
| Prior stay at this nursing home | a. |
| Stay in other nursing home | b. |
| Other residential facility—board and care home, assisted living, group home | c. |
| MH/psychiatric setting | d. |
| MR/DD setting | e. |
| *NONE OF ABOVE* | f. |

**6. LIFETIME OCCUPATION(S)** [Put "/" between two occupations]

**7. EDUCATION (*Highest Level Completed*)**
1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

**8. LANGUAGE** — *(Code for correct response)*

a. Primary Language
0. English 1. Spanish 2. French 3. Other

b. If other, specify

**9. MENTAL HEALTH HISTORY** — Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?
0. No 1. Yes

**10. CONDITIONS RELATED TO MR/DD STATUS** — *(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)*

| | |
|---|---|
| Not applicable—no MR/DD (Skip to AB11) | a. |
| MR/DD with organic condition | |
| Down's syndrome | b. |
| Autism | c. |
| Epilepsy | d. |
| Other organic condition related to MR/DD | e. |
| MR/DD with no organic condition | f. |

**11. DATE BACKGROUND INFORMATION COMPLETED**

Month ___ Day ___ Year ___

## SECTION AC. CUSTOMARY ROUTINE

**1. CUSTOMARY ROUTINE** (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*) — *(Check all that apply. If all information UNKNOWN, check last box only.)*

| | |
|---|---|
| **CYCLE OF DAILY EVENTS** | |
| Stays up late at night (e.g., after 9 pm) | a. |
| Naps regularly during day (at least 1 hour) | b. |
| Goes out 1+ days a week | c. |
| Stays busy with hobbies, reading, or fixed daily routine | d. |
| Spends most of time alone or watching TV | e. |
| Moves independently indoors (with appliances, if used) | f. |
| Use of tobacco products at least daily | g. |
| *NONE OF ABOVE* | h. |
| **EATING PATTERNS** | |
| Distinct food preferences | i. |
| Eats between meals all or most days | j. |
| Use of alcoholic beverage(s) at least weekly | k. |
| *NONE OF ABOVE* | l. |
| **ADL PATTERNS** | |
| In bedclothes much of day | m. |
| Wakens to toilet all or most nights | n. |
| Has irregular bowel movement pattern | o. |
| Showers for bathing | p. |
| Bathing in PM | q. |
| *NONE OF ABOVE* | r. |
| **INVOLVEMENT PATTERNS** | |
| Daily contact with relatives/close friends | s. |
| Usually attends church, temple, synagogue (etc.) | t. |
| Finds strength in faith | u. |
| Daily animal companion/presence | v. |
| Involved in group activities | w. |
| *NONE OF ABOVE* | x. |
| **UNKNOWN**—Resident/family unable to provide information | y. |

## SECTION AD. FACE SHEET SIGNATURES

**SIGNATURES OF PERSONS COMPLETING FACE SHEET:**

a. Signature of RN Assessment Coordinator — Date

b. Signatures — Title — Sections

c. — Date

d. — Date

e. — Date

f. — Date

g. — Date

Resident _____ Numeric Identifier _____

**2. BATHING** — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below

| | (A) | (B) |
|---|---|---|
| 0. Independent—No help provided | | |
| 1. Supervision—Oversight help only | | |
| 2. Physical help limited to transfer only | | |
| 3. Physical help in part of bathing activity | | |
| 4. Total dependence | | |
| 8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)* | | |

**3. TEST FOR BALANCE** (see training manual) — *(Code for ability during test in the last 7 days)*
0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

| | |
|---|---|
| a. Balance while standing | |
| b. Balance while sitting—position, trunk control | |

**4. FUNCTIONAL LIMITATION IN RANGE OF MOTION** (see training manual) — *(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)*
(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

| | (A) | (B) |
|---|---|---|
| a. Neck | | |
| b. Arm—Including shoulder or elbow | | |
| c. Hand—Including wrist or fingers | | |
| d. Leg—Including hip or knee | | |
| e. Foot—Including ankle or toes | | |
| f. Other limitation or loss | | |

**5. MODES OF LOCOMOTION** — *(Check all that apply during last 7 days)*

| | | | |
|---|---|---|---|
| Cane/walker/crutch | a. | Wheelchair primary mode of locomotion | d. |
| Wheeled self | b. | | |
| Other person wheeled | c. | *NONE OF ABOVE* | e. |

**6. MODES OF TRANSFER** — *(Check all that apply during last 7 days)*

| | | | |
|---|---|---|---|
| Bedfast all or most of time | a. | Lifted mechanically | d. |
| Bed rails used for bed mobility or transfer | b. | Transfer aid (e.g., slide board, trapeze, cane, walker, brace) | e. |
| Lifted manually | c. | *NONE OF ABOVE* | f. |

**7. TASK SEGMENTATION** — Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them. 0. No 1. Yes

**8. ADL FUNCTIONAL REHABILITATION POTENTIAL**

| | |
|---|---|
| Resident believes he/she is capable of increased independence in at least some ADLs | a. |
| Direct care staff believe resident is capable of increased independence in at least some ADLs | b. |
| Resident able to perform tasks/activity but is very slow | c. |
| Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings | d. |
| *NONE OF ABOVE* | e. |

**9. CHANGE IN ADL FUNCTION** — Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

## SECTION H. CONTINENCE IN LAST 14 DAYS

**1. CONTINENCE SELF-CONTROL CATEGORIES** *(Code for resident's PERFORMANCE OVER ALL SHIFTS)*

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

| | | |
|---|---|---|
| a. | BOWEL CONTINENCE | Control of bowel movement, with appliance or bowel continence programs, if employed |
| b. | BLADDER CONTINENCE | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed |

**2. BOWEL ELIMINATION PATTERN** — Bowel elimination pattern regular—at least one movement every three days

| | | | |
|---|---|---|---|
| | a. | Diarrhea | c. |
| | | Fecal impaction | d. |
| Constipation | b. | *NONE OF ABOVE* | e. |

**3. APPLIANCES AND PROGRAMS** — Any scheduled toileting plan

| | | | |
|---|---|---|---|
| Bladder retraining program | a. | Did not use toilet room/ commode/urinal | f. |
| External (condom) catheter | b. | Pads/briefs used | g. |
| Indwelling catheter | c. | Enemas/irrigation | h. |
| Intermittent catheter | d. | Ostomy present | i. |
| | e. | *NONE OF ABOVE* | j. |

**4. CHANGE IN URINARY CONTINENCE** — Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

## SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

**1. DISEASES** — *(If none apply, CHECK the NONE OF ABOVE box)*

| | | | |
|---|---|---|---|
| ENDOCRINE/METABOLIC/ NUTRITIONAL | | Hemiplegia/Hemiparesis | v. |
| | | Multiple sclerosis | w. |
| Diabetes mellitus | a. | Paraplegia | x. |
| Hyperthyroidism | b. | Parkinson's disease | y. |
| Hypothyroidism | c. | Quadriplegia | z. |
| HEART/CIRCULATION | | Seizure disorder | aa. |
| Arteriosclerotic heart disease (ASHD) | d. | Transient ischemic attack (TIA) | bb. |
| Cardiac dysrhythmias | e. | Traumatic brain injury | cc. |
| Congestive heart failure | f. | PSYCHIATRIC/MOOD | |
| Deep vein thrombosis | g. | Anxiety disorder | dd. |
| Hypertension | h. | Depression | ee. |
| Hypotension | i. | Manic depression (bipolar disease) | ff. |
| Peripheral vascular disease | j. | Schizophrenia | gg. |
| Other cardiovascular disease | k. | PULMONARY | |
| MUSCULOSKELETAL | | Asthma | hh. |
| Arthritis | l. | Emphysema/COPD | ii. |
| Hip fracture | m. | SENSORY | |
| Missing limb (e.g., amputation) | n. | Cataracts | jj. |
| Osteoporosis | o. | Diabetic retinopathy | kk. |
| Pathological bone fracture | p. | Glaucoma | ll. |
| NEUROLOGICAL | | Macular degeneration | mm. |
| Alzheimer's disease | q. | OTHER | |
| Aphasia | r. | Allergies | nn. |
| Cerebral palsy | s. | Anemia | oo. |
| Cerebrovascular accident (stroke) | t. | Cancer | pp. |
| | | Renal failure | qq. |
| Dementia other than Alzheimer's disease | u. | *NONE OF ABOVE* | rr. |

**2. INFECTIONS** — *(If none apply, CHECK the NONE OF ABOVE box)*

| | | | |
|---|---|---|---|
| Antibiotic resistant infection (e.g., Methicillin resistant staph) | a. | Septicemia | g. |
| | | Sexually transmitted diseases | h. |
| Clostridium difficile (c. diff.) | b. | Tuberculosis | i. |
| Conjunctivitis | c. | Urinary tract infection in last 30 days | j. |
| HIV infection | d. | Viral hepatitis | k. |
| Pneumonia | e. | Wound infection | l. |
| Respiratory infection | f. | NONE OF ABOVE | m. |

**3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES**

| | | |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |
| e. | | |

## SECTION J. HEALTH CONDITIONS

**1. PROBLEM CONDITIONS** — *(Check all problems present in last 7 days unless other time frame is indicated)*

| | | | |
|---|---|---|---|
| INDICATORS OF FLUID STATUS | | Dizziness/Vertigo | f. |
| | | Edema | g. |
| Weight gain or loss of 3 or more pounds within a 7 day period | a. | Fever | h. |
| | | Hallucinations | i. |
| | | Internal bleeding | j. |
| Inability to lie flat due to shortness of breath | b. | Recurrent lung aspirations in last 90 days | k. |
| Dehydrated; output exceeds input | c. | Shortness of breath | l. |
| | | Syncope (fainting) | m. |
| Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days | | Unsteady gait | n. |
| | d. | Vomiting | o. |

Resident _____ Numeric Identifier _____

| | | | |
|---|---|---|---|
| 2. | PAIN SYMPTOMS | *(Code the highest level of pain present in the last 7 days)* | |
| | | a. FREQUENCY with which resident complains or shows evidence of pain<br>0. No pain *(skip to J4)*<br>1. Pain less than daily<br>2. Pain daily | b. INTENSITY of pain<br>1. Mild pain<br>2. Moderate pain<br>3. Times when pain is horrible or excruciating |
| 3. | PAIN SITE | *(If pain present, check all sites that apply in last 7 days)* | |
| | | Back pain a. | Incisional pain f. |
| | | Bone pain b. | Joint pain (other than hip) g. |
| | | Chest pain while doing usual activities c. | Soft tissue pain (e.g., lesion, muscle) h. |
| | | Headache d. | Stomach pain i. |
| | | Hip pain e. | Other j. |
| 4. | ACCIDENTS | *(Check all that apply)* | |
| | | Fell in past 30 days a. | Hip fracture in last 180 days c. |
| | | Fell in past 31-180 days b. | Other fracture in last 180 days d. |
| | | | *NONE OF ABOVE* e. |
| 5. | STABILITY OF CONDITIONS | Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) a. | |
| | | Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem b. | |
| | | End-stage disease, 6 or fewer months to live c. | |
| | | *NONE OF ABOVE* d. | |

## SECTION K. ORAL/NUTRITIONAL STATUS

| | | | |
|---|---|---|---|
| 1. | ORAL PROBLEMS | Chewing problem a. | |
| | | Swallowing problem b. | |
| | | Mouth pain c. | |
| | | *NONE OF ABOVE* d. | |
| 2. | HEIGHT AND WEIGHT | *Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*<br>a. HT (in.) ___ b. WT (lb.) ___ | |
| 3. | WEIGHT CHANGE | a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days<br>0. No 1. Yes | |
| | | b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days<br>0. No 1. Yes | |
| 4. | NUTRITIONAL PROBLEMS | Complains about the taste of many foods a. | Leaves 25% or more of food uneaten at most meals c. |
| | | Regular or repetitive complaints of hunger b. | *NONE OF ABOVE* d. |
| 5. | NUTRITIONAL APPROACHES | *(Check all that apply in last 7 days)* | |
| | | Parenteral/IV a. | Dietary supplement between meals f. |
| | | Feeding tube b. | Plate guard, stabilized built-up utensil, etc. g. |
| | | Mechanically altered diet c. | On a planned weight change program h. |
| | | Syringe (oral feeding) d. | *NONE OF ABOVE* i. |
| | | Therapeutic diet e. | |
| 6. | PARENTERAL OR ENTERAL INTAKE | *(Skip to Section L if neither 5a nor 5b is checked)*<br>a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days<br>0. None 3. 51% to 75%<br>1. 1% to 25% 4. 76% to 100%<br>2. 26% to 50% | |
| | | b. Code the average fluid intake per day by IV or tube in last 7 days<br>0. None 3. 1001 to 1500 cc/day<br>1. 1 to 500 cc/day 4. 1501 to 2000 cc/day<br>2. 501 to 1000 cc/day 5. 2001 or more cc/day | |

## SECTION L. ORAL/DENTAL STATUS

| | | | |
|---|---|---|---|
| 1. | ORAL STATUS AND DISEASE PREVENTION | Debris (soft, easily movable substances) present in mouth prior to going to bed at night a. | |
| | | Has dentures or removable bridge b. | |
| | | Some/all natural teeth lost—does not have or does not use dentures (or partial plates) c. | |
| | | Broken, loose, or carious teeth d. | |
| | | Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes e. | |

## SECTION M. SKIN CONDITION

| | | | |
|---|---|---|---|
| 1. | ULCERS (Due to any cause) | *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that ap during last 7 days. Code 9 = 9 or more.) [Requires full body exa* | |
| | | a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. | |
| | | b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. | |
| | | c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. | |
| | | d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. | |
| 2. | TYPE OF ULCER | *(For each type of ulcer, code for the highest stage in the last 7 day using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)*<br>a. Pressure ulcer—any lesion caused by pressure resulting in damag of underlying tissue<br>b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities | |
| 3. | HISTORY OF RESOLVED ULCERS | Resident had an ulcer that was resolved or cured in LAST 90 DAYS<br>0. No 1. Yes | |
| 4. | OTHER SKIN PROBLEMS OR LESIONS PRESENT | *(Check all that apply during last 7 days)*<br>Abrasions, bruises<br>Burns (second or third degree)<br>Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)<br>Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster<br>Skin desensitized to pain or pressure<br>Skin tears or cuts (other than surgery)<br>Surgical wounds<br>*NONE OF ABOVE* | |
| 5. | SKIN TREATMENTS | *(Check all that apply during last 7 days)*<br>Pressure relieving device(s) for chair<br>Pressure relieving device(s) for bed<br>Turning/repositioning program<br>Nutrition or hydration intervention to manage skin problems<br>Ulcer care<br>Surgical wound care<br>Application of dressings (with or without topical medications) other tha to feet<br>Application of ointments/medications (other than to feet)<br>Other preventative or protective skin care (other than to feet)<br>*NONE OF ABOVE* | |
| 6. | FOOT PROBLEMS AND CARE | *(Check all that apply during last 7 days)*<br>Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems<br>Infection of the foot—e.g., cellulitis, purulent drainage<br>Open lesions on the foot<br>Nails/calluses trimmed during last 90 days<br>Received preventative or protective foot care (e.g., used special shoe inserts, pads, toe separators)<br>Application of dressings (with or without topical medications)<br>*NONE OF ABOVE* | |

## SECTION N. ACTIVITY PURSUIT PATTERNS

| | | | |
|---|---|---|---|
| 1. | TIME AWAKE | *(Check appropriate time periods over last 7 days)*<br>Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: | |
| | | Morning a. | Evening |
| | | Afternoon b. | *NONE OF ABOVE* |
| | | If resident is comatose, skip to Section O) | |
| 2. | AVERAGE TIME INVOLVED IN ACTIVITIES | *(When awake and not receiving treatments or ADL care)*<br>0. Most—more than 2/3 of time 2. Little—less than 1/3 of time<br>1. Some—from 1/3 to 2/3 of time 3. None | |
| 3. | PREFERRED ACTIVITY SETTINGS | *(Check all settings in which activities are preferred)*<br>Own room a. | Outside facility |
| | | Day/activity room b. | *NONE OF ABOVE* |
| | | Inside NH/off unit c. | |
| 4. | GENERAL ACTIVITY PREFERENCES (adapted to resident's | *(Check all PREFERENCES whether or not activity is currently available to resident)*<br>Cards/other games a. | Trips/shopping |
| | | Crafts/arts b. | Walking/wheeling outdoors |
| | | Exercise/sports c. | Watching TV |

Resident _____ Numeric Identifier _____

# MINIMUM DATA SET (MDS) — *VERSION 2.0*
## FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
## *FULL ASSESSMENT FORM*
(Status in last 7 days, unless other time frame indicated)

## SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. ROOM NUMBER
3. ASSESSMENT REFERENCE DATE — a. *Last day of MDS observation period* (Month — Day — Year); b. Original (0) or corrected copy of form (enter number of correction)
4a. DATE OF REENTRY — Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) (Month — Day — Year)
5. MARITAL STATUS — 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
6. MEDICAL RECORD NO.
7. CURRENT PAYMENT SOURCES FOR N.H. STAY — (Billing Office to indicate, check all that apply in last 30 days)
   - a. Medicaid per diem
   - b. Medicare per diem
   - c. Medicare ancillary part A
   - d. Medicare ancillary part B
   - e. CHAMPUS per diem
   - f. VA per diem
   - g. Self or family pays for full per diem
   - h. Medicaid resident liability or Medicare co-payment
   - i. Private insurance per diem (including co-payment)
   - j. Other per diem
8. REASONS FOR ASSESSMENT — *[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]*
   a. Primary reason for assessment
   1. Admission assessment (required by day 14)
   2. Annual assessment
   3. Significant change in status assessment
   4. Significant correction of prior full assessment
   5. Quarterly review assessment
   6. Discharged—return not anticipated
   7. Discharged—return anticipated
   8. Discharged prior to completing initial assessment
   9. Reentry
   10. Significant correction of prior quarterly assessment
   0. *NONE OF ABOVE*

   b. *Codes for assessments required for Medicare PPS or the State*
   *1. Medicare 5 day assessment*
   *2. Medicare 30 day assessment*
   *3. Medicare 60 day assessment*
   *4. Medicare 90 day assessment*
   *5. Medicare readmission/return assessment*
   *6. Other state required assessment*
   *7. Medicare 14 day assessment*
   *8. Other Medicare required assessment*
9. RESPONSIBILITY/ LEGAL GUARDIAN — (Check all that apply)
   - a. Legal guardian
   - b. Other legal oversight
   - c. Durable power of attorney/health care
   - d. Durable power attorney/financial
   - e. Family member responsible
   - f. Patient responsible for self
   - g. *NONE OF ABOVE*
10. ADVANCED DIRECTIVES — *(For those items with supporting documentation in the medical record, check all that apply)*
    - a. Living will
    - b. Do not resuscitate
    - c. Do not hospitalize
    - d. Organ donation
    - e. Autopsy request
    - f. Feeding restrictions
    - g. Medication restrictions
    - h. Other treatment restrictions
    - i. *NONE OF ABOVE*

## SECTION B. COGNITIVE PATTERNS

1. COMATOSE — (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)
2. MEMORY — (Recall of what was learned or known)
   a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
   b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
3. MEMORY/ RECALL ABILITY — (Check all that resident was normally able to recall during last 7 days)
   - a. Current season
   - b. Location of own room
   - c. Staff names/faces
   - d. That he/she is in a nursing home
   - e. *NONE OF ABOVE* are recalled
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING — (Made decisions regarding tasks of daily life)
   0. *INDEPENDENT*—decisions consistent/reasonable
   1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
   2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
   3. *SEVERELY IMPAIRED*—never/rarely made decisions
5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS — (Code for behavior in the last 7 days.) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].
   0. Behavior not present
   1. Behavior present, not of recent onset
   2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)
   - a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
   - b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
   - c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
   - d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
   - e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
   - f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6. CHANGE IN COGNITIVE STATUS — Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

## SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING — (With hearing appliance, if used)
   0. *HEARS ADEQUATELY*—normal talk, TV, phone
   1. *MINIMAL DIFFICULTY* when not in quiet setting
   2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
   3. *HIGHLY IMPAIRED*/absence of useful hearing
2. COMMUNICATION DEVICES/ TECHNIQUES — (Check all that apply during last 7 days)
   - a. Hearing aid, present and used
   - b. Hearing aid, present and not used regularly
   - c. Other receptive comm. techniques used (e.g., lip reading)
   - d. *NONE OF ABOVE*
3. MODES OF EXPRESSION — (Check all used by resident to make needs known)
   - a. Speech
   - b. Writing messages to express or clarify needs
   - c. American sign language or Braille
   - d. Signs/gestures/sounds
   - e. Communication board
   - f. Other
   - g. *NONE OF ABOVE*
4. MAKING SELF UNDERSTOOD — (Expressing information content—however able)
   0. *UNDERSTOOD*
   1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
   2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
   3. *RARELY/NEVER UNDERSTOOD*
5. SPEECH CLARITY — (Code for speech in the last 7 days)
   0. *CLEAR SPEECH*—distinct, intelligible words
   1. *UNCLEAR SPEECH*—slurred, mumbled words
   2. *NO SPEECH*—absence of spoken words
6. ABILITY TO UNDERSTAND OTHERS — (Understanding verbal information content—however able)
   0. *UNDERSTANDS*
   1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
   2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
   3. *RARELY/NEVER UNDERSTANDS*
7. CHANGE IN COMMUNICATION/ HEARING — Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change

Resident _____ Numeric Identifier _____

## SEC-I-ION D. VISION PATTERNS

| | | | |
|---|---|---|---|
| 1. | VISION | *(Ability to see in adequate light and with glasses if used)*<br>0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books<br>1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books<br>2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects<br>3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects<br>4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects | |
| 2. | VISUAL LIMITATIONS/ DIFFICULTIES | Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) | a. |
| | | Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes | b. |
| | | *NONE OF ABOVE* | c. |
| 3. | VISUAL APPLIANCES | Glasses; contact lenses; magnifying glass<br>0. No 1. Yes | |

## SECTION E. MOOD AND BEHAVIOR PATTERNS

| | | | |
|---|---|---|---|
| 1. | INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD | *(Code for indicators observed in last 30 days, irrespective of the assumed cause)*<br>0. Indicator not exhibited in last 30 days<br>1. Indicator of this type exhibited up to five days a week<br>2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) | |
| | | VERBAL EXPRESSIONS OF DISTRESS | |
| | | a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*" | |
| | | b. Repetitive questions—e.g., "*Where do I go; What do I do?*" | |
| | | c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*") | |
| | | d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received | |
| | | e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*" | |
| | | f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others | |
| | | g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack | |
| | | h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions | |
| | | i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues | |
| | | SLEEP-CYCLE ISSUES | |
| | | j. Unpleasant mood in morning | |
| | | k. Insomnia/change in usual sleep pattern | |
| | | SAD, APATHETIC, ANXIOUS APPEARANCE | |
| | | l. Sad, pained, worried facial expressions—e.g., furrowed brows | |
| | | m. Crying, tearfulness | |
| | | n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking | |
| | | LOSS OF INTEREST | |
| | | o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends | |
| | | p. Reduced social interaction | |
| 2. | MOOD PERSISTENCE | One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days<br>0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered | |
| 3. | CHANGE IN MOOD | Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>0. No change 1. Improved 2. Deteriorated | |
| 4. | BEHAVIORAL SYMPTOMS | (A) *Behavioral symptom frequency in last 7 days*<br>0. Behavior not exhibited in last 7 days<br>1. Behavior of this type occurred 1 to 3 days in last 7 days<br>2. Behavior of this type occurred 4 to 6 days, but less than daily<br>3. Behavior of this type occurred daily<br>(B) *Behavioral symptom alterability in last 7 days*<br>0. Behavior not present OR behavior was easily altered<br>1. Behavior was not easily altered | (A) (B) |
| | | a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) | |
| | | b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) | |
| | | c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) | |
| | | d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) | |
| | | e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) | |

| | | | |
|---|---|---|---|
| 5. | CHANGE IN BEHAVIORAL SYMPTOMS | Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>0. No change 1. Improved 2. Deteriorated | |

## SECTION F. PSYCHOSOCIAL WELL-BEING

| | | | |
|---|---|---|---|
| 1. | SENSE OF INITIATIVE/ INVOLVEMENT | At ease interacting with others | a. |
| | | At ease doing planned or structured activities | b. |
| | | At ease doing self-initiated activities | c. |
| | | Establishes own goals | d. |
| | | Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) | e. |
| | | Accepts invitations into most group activities | f. |
| | | *NONE OF ABOVE* | g. |
| 2. | UNSETTLED RELATIONSHIPS | Covert/open conflict with or repeated criticism of staff | a. |
| | | Unhappy with roommate | b. |
| | | Unhappy with residents other than roommate | c. |
| | | Openly expresses conflict/anger with family/friends | d. |
| | | Absence of personal contact with family/friends | e. |
| | | Recent loss of close family member/friend | f. |
| | | Does not adjust easily to change in routines | g. |
| | | *NONE OF ABOVE* | h. |
| 3. | PAST ROLES | Strong identification with past roles and life status | a. |
| | | Expresses sadness/anger/empty feeling over lost roles/status | b. |
| | | Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community | c. |
| | | *NONE OF ABOVE* | d. |

## SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—*(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT*—No help or oversight—OR—Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times dur last7 days —OR— Supervision (3 or more times) plus physical assistance provide 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—*(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

| | | | (A) SELF-PERF | (B) SUPPORT |
|---|---|---|---|---|
| a. | BED MOBILITY | How resident moves to and from lying position, turns side to side, and positions body while in bed | | |
| b. | TRANSFER | How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) | | |
| c. | WALK IN ROOM | How resident walks between locations in his/her room | | |
| d. | WALK IN CORRIDOR | How resident walks in corridor on unit | | |
| e. | LOCOMOTION ON UNIT | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair | | |
| f. | LOCOMOTION OFF UNIT | How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair | | |
| g. | DRESSING | How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis | | |
| h. | EATING | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) | | |
| i. | TOILET USE | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes | | |
| j. | PERSONAL HYGIENE | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) | | |

Resident _____ Numeric Identifier _____

| | | |
|---|---|---|
| 5. | PREFERS CHANGE IN DAILY ROUTINE | *Code for resident preferences in daily routines*<br>0. No change 1. Slight change 2. Major change<br>a. Type of activities in which resident is currently involved<br>b. Extent of resident involvement in activities |

## SECTION O. MEDICATIONS

| | | |
|---|---|---|
| 1. | NUMBER OF MEDICATIONS | *(Record the number of different medications used in the last 7 days; enter "0" if none used)* |
| 2. | NEW MEDICATIONS | *(Resident currently receiving medications that were initiated during the last 90 days)*<br>0. No 1. Yes |
| 3. | INJECTIONS | *(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)* |
| 4. | DAYS RECEIVED THE FOLLOWING MEDICATION | *(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)*<br>a. Antipsychotic<br>b. Antianxiety<br>c. Antidepressant<br>d. Hypnotic<br>e. Diuretic |

## SECTION P. SPECIAL TREATMENTS AND PROCEDURES

| | | |
|---|---|---|
| 1. | SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS | a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*<br>**TREATMENTS**<br>Chemotherapy (a.)<br>Dialysis (b.)<br>IV medication (c.)<br>Intake/output (d.)<br>Monitoring acute medical condition (e.)<br>Ostomy care (f.)<br>Oxygen therapy (g.)<br>Radiation (h.)<br>Suctioning (i.)<br>Tracheostomy care (j.)<br>Transfusions (k.)<br>Ventilator or respirator (l.)<br>**PROGRAMS**<br>Alcohol/drug treatment program (m.)<br>Alzheimer's/dementia special care unit (n.)<br>Hospice care (o.)<br>Pediatric unit (p.)<br>Respite care (q.)<br>Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) (r.)<br>*NONE OF ABOVE* (s.) |
| | | b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*<br>[Note—count only post admission therapies]<br>(A) = # of days administered for 15 minutes or more<br>(B) = total # of minutes provided in last 7 days<br>a. Speech - language pathology and audiology services<br>b. Occupational therapy<br>c. Physical therapy<br>d. Respiratory therapy<br>e. Psychological therapy (by any licensed mental health professional) |
| 2. | INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS | (Check all interventions or strategies used in last 7 days—no matter where received)<br>Special behavior symptom evaluation program (a.)<br>Evaluation by a licensed mental health specialist in last 90 days (b.)<br>Group therapy (c.)<br>Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage (d.)<br>Reorientation—e.g., cueing (e.)<br>*NONE OF ABOVE* (f.) |
| 3. | NURSING REHABILITATION/ RESTORATIVE CARE | *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*<br>a. Range of motion (passive)<br>b. Range of motion (active)<br>c. Splint or brace assistance<br>TRAINING AND SKILL PRACTICE IN:<br>d. Bed mobility<br>e. Transfer<br>f. Walking<br>g. Dressing or grooming<br>h. Eating or swallowing<br>i. Amputation/prosthesis care<br>j. Communication<br>k. Other |

| | | |
|---|---|---|
| 4. | DEVICES AND RESTRAINTS | *(Use the following codes for last 7 days:)*<br>0. Not used<br>1. Used less than daily<br>2. Used daily<br>Bed rails<br>a. — Full bed rails on all open sides of bed<br>b. — Other types of side rails used (e.g., half rail, one side)<br>c. Trunk restraint<br>d. Limb restraint<br>e. Chair prevents rising |
| 5. | HOSPITAL STAY(S) | Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)* |
| 6. | EMERGENCY ROOM (ER) VISIT(S) | Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)* |
| 7. | PHYSICIAN VISITS | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)* |
| 8. | PHYSICIAN ORDERS | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)* |
| 9. | ABNORMAL LAB VALUES | Has the resident had any abnormal lab values during the last 90 days (or since admission)?<br>0. No 1. Yes |

## SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

| | | |
|---|---|---|
| 1. | DISCHARGE POTENTIAL | a. Resident expresses/indicates preference to return to the community<br>0. No 1. Yes<br>b. Resident has a support person who is positive towards discharge<br>0. No 1. Yes<br>c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death)<br>0. No 2. Within 31-90 days<br>1. Within 30 days 3. Discharge status uncertain |
| 2. | OVERALL CHANGE IN CARE NEEDS | Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support |

## SECTION R. ASSESSMENT INFORMATION

| | | |
|---|---|---|
| 1. | PARTICIPATION IN ASSESSMENT | a. Resident: 0. No 1. Yes<br>b. Family: 0. No 1. Yes 2. No family<br>c. Significant other: 0. No 1. Yes 2. None |
| 2. | SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: | |

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete ___ Month ___ Day ___ Year

| c. Other Signatures | Title | Sections | Date |
|---|---|---|---|
| d. | | | Date |
| e. | | | Date |
| f. | | | Date |
| g. | | | Date |
| h. | | | Date |

Resident _____ Numeric Identifier _____

## SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

**1 SPECIAL TREATMENTS AND PROCEDURES**

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*

| | DAYS (A) | MIN (B) |
|---|---|---|
| (A) = # of days administered for 15 minutes or more<br>(B) = total # of minutes provided in last 7 days | | |

*Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.*

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

***If not ordered, skip to item 2***

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

**2 WALKING WHEN MOST SELF SUFFICIENT**

***Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:***
- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

***Skip to item 3 if resident did not walk in last 7 days***

***(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)***

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

**3 CASE MIX GROUP**

Medicare _____ State _____

## SECTION U. MEDICATIONSCASE MIX DEMO

List all medications that the resident received during the last 7 days. Include scheduled medications that are used regularly, but less than weekly.

1. Medication Name and Dose Ordered. Record the name of the medication and dose ordered
2. Route of Administration (RA). Code the Route of Administration using the following list:

| | | |
|---|---|---|
| 1=by mouth (PO) | 5=subcutaneous (SQ) | 8=inhalation |
| 2=sub lingual (SL) | 6=rectal (R) | 9=enteral tube |
| 3=intramuscular (IM) | 7=topical | 10=other |
| 4=intravenous (IV) | | |

3. Frequency. Code the number of times per day, week, or month the medication is administered using the following list:

| | | |
|---|---|---|
| PR=(PRN) as necessary | 2D=(BID) two times daily (includes every 12 hrs) | QO=every other day |
| 1H=(QH) every hour | 3D=(TID) three times daily | 4W=4 times each week |
| 2H=(Q2H) every two hours | 4D=(QID) four times daily | 5W=five times each week |
| 3H=(Q3H) every three hours | 5D=five times daily | 6W=six times each week |
| 4H=(Q4H) every four hours | 1W=(Q week) once each wk | 1M=(Q month) once every month |
| 6H=(Q6H) every six hours | 2W=two times every week | 2M=twice every month |
| 8H=(Q8H) every eight hours | 3W=three times every week | C=continuous |
| 1D=(QD or HS) once daily | | O=other |

4. Amount Administered (AA). Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. PRN-number of days (PRN-n). If the frequency code for the medication is "PR", record the *number* of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. NDC Codes. Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| | | | | | |
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# CHAPTER 2: USING THE RAI: STATUTORY AND REGULATORY REQUIREMENTS AND SUGGESTIONS FOR INTEGRATION IN CLINICAL PRACTICE


**This chapter presents the regulatory basis for the RAI and discusses how the RAI process can be implemented procedurally in the course of clinical practice with facility residents. Some of the procedures are required by statutory law, Federal regulation or HCFA utilization guidelines, while others are recommended based on sound experience of facilities that have used the RAI process successfully.**

## 12.1 Statutory and Regulatory Basis for the RAI

The statutory authority for the Minimum Data Set (MDS) and the Resident Assessment Instrument (RAI) is found in section 1819 (f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the.Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a n&mum data set of core elements to use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995.

Federal requirements[1] at 42 CFR 483.20 (b)(l)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and helps staff to identify health problems.

## 12.2 Content of the RAI

**All State RAIs include at least the Health Care Financing Administration's (HCFA's):**

- **MDS**
- **Triggers**
- **Resident Assessment Protocols (RAPS)**
- **Utilization Guidelines**

[1]For further information regarding the statutory basis for the RAI, see Appendix G.

Some States have added items to the core MDS that must be completed for each resident when an RAI comprehensive assessment is required. Thus, while the basic MDS form (as included in this manual) is the standard foundation for States, you may find that other items have been added at the end of the form (i.e., Sections S, T, or U) in your State.

Additionally, States must specify a Quarterly Assessment Form for use by facilities that includes at least the items on the HCFA-designated form. (See Section 2.4 **and Appendix B of this manual for a list of the items.)** Several States have also expanded the list of MDS items that must be documented on the resident's Quarterly Assessment.

HCFA's approval of a State's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. HCFA's approval of the RAI does not include, characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI form 'in the resident's record accurately and completely represents the State's RAI as approved by HCFA in accordance with 42 CFR 483.20 (b). This applies to either pre-printed forms or computer generated printouts. States also have the prerogative of requiring facilities to use the State form. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems 'must always be based on the MDS (i.e., both item terminology and definitions).

Additional information about State specification of the RAI, variations in format and HCFA approval of alternative State instruments can be found in Sections 4145.1 - 4145.6 of the HCFA State Operations Manual, Transmittal #272 issued April 1995.

To fulfill Federal requirements at 42 CFR 483.20, each time a comprehensive assessment is required,. long term care facilities must complete:

- The MDS, plus any additional core **items that m&e up the State RAI;**
- The RAP Summary form, on which facilities must indicate which RAPs have been triggered, the location of information gathered during the RAP review process, and the final care planning decision; and
- Documentation of clinical information (e.g., assessment information) from the RAP review to assist in care planning and follow-up.

The following is a schematic of the overall RAI framework:

MDS + TRIGGERS + RAPS ——————> COMPREHENSIVE
(UTILIZATION GUIDELINES) ASSESSMENT

The MDS consists of a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment.

The triggers are specific resident responses for one or a combination of MDS elements. The triggers identify residents who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPs) designated within the State-specified RAI. MDS item responses that define triggers are specified in each RAP and on the Trigger Legend form. Turn to the RAPs (in Appendix C) to review these items and the accompanying RAP Guidelines. Once you are familiar with the RAP triggers and guidelines, the Trigger Legend form serves as a useful summary of all RAP triggers. Note that the symbols on this form have been changed and the process streamlined. The Trigger Legend summarizes which MDS item responses trigger individual RAPs and has been designed as a helpful tool for facilities if they choose to use it. It is a worksheet, not a required form, and does not need to be maintained in each resident's clinical record.

The RAPs provide structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the RAP in question? Clinical staff are responsible for answering questions such as these. The information from the MDS and RAPs forms the basis for individualized care planning.

The Utilization Guidelines are instructions concerning when and how to use the RAI. The Utilization Guidelines for Version 2.0 of the RAI were published by HCFA in the State Operations Manual[2] Transmittal #272, and are discussed more extensively in this User's Manual.

The individual resident's care plan must be evaluated and revised, if appropriate, each time an RAI comprehensive assessment is completed. Facilities may either make changes on the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI, may be documented in the resident's active record. This documentation should include progress notes or facility specific flowsheets.

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[2]The SOM is a reference only; it is not necessary for effective use of the RAI. The SOM can be ordered from the National Technical Information Service (NTIS); PB# 95-950007; $27; (703) 487-465

## 2.3 Applicability of RAI to Facility Residents

The requirements for resident assessment found at 42 CFR 483.20 are applicable to all residents in certified long term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay or payment category.

An RAI must be completed for any resident residing in the facility longer than 14 days, including:

- All residents of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes distinct part certified SNFs or NFs and certified SNFs or NFs in hospitals, regardless of payment source.

- Hospice Residents. When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between the hospice and long term care facility staff with the consent of the resident. In these situations, the hospice team may participate in completing the RAI.

- Short term stay or respite residents. An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long term care facility for participation in the Medicare or Medicaid programs.

  Given the nature of short stay or respite admissions, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may not be able to provide information on the resident's Customary Routine.) In that case the "no-information" convention should be used. ("NA" or "circled" dash - See Section 2.7 for more information.) For respite residents who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be discharged to "extended" leave status. This status does not. require: reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred in the intervening period.

- Special populations (e.g. pediatric or residents with a psychiatric diagnosis). Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.

An RAI is not required for:

- SNF residents residing in a Medicare certified "swing-bed" hospital. The requirement for a comprehensive assessment is not incorporated in the long term care requirements for "swing-bed" hospitals-at 42 CFR 482.66.

- Individuals residing: in non-certified units of long term care facilities or licensed only facilities. This does not preclude a State from mandating the RAI for residents who live in these units.

## 12.4 Types of RAI Assessments and Timing of Assessments

Although the RAI assessments discussed in the following; section must occur at specific times by Federal regulation, a facility's obligation to meet each resident's needs through ongoing assessment is not neatly confined to these mandated time frames. Likewise, completion of the RAI in the prescribed time frame does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI.

Comprehensive RAI assessments require completion of the MDS and review of triggered RAPs, followed by development or review of the comprehensive care plan within 7 days of completion of the RAI. The following table summarizes the different types of Federally mandated assessments:

| TYPE OF ASSESSMENT | TIMING OF ASSESSMENT | REGULATORY REQUIREMENT HCFA "F" TAG |
|---|---|---|
| Admission (Initial) Assessment | Must be completed by 14th day of resident's stay. | 42 CFR 483.20 (b)(4)(i)/F 273 |
| Annual Reassessment | Must be completed within 12 months of most recent full assessment. | 42 CFR 483.20 (b)(4)(v)/F 275 |
| Significant Change in Status Reassessment | Must be completed by the end of the 14th calendar day following determination that a significant change has occurred. | 42 CFR 483.20 (b)(4)(iv)/F 274 |
| Quarterly Assessment | Set of MDS items, mandated by State (contains at least HCFA established subset, of MDS items). Must be completed no less frequently than once every 3 months. | 42 CFR 483.20 (b)(5)/F 276 |

## ADMISSION (INITIAL) ASSESSMENTS

The admission or initial assessment for a new resident must be completed by the **end** of the **14th calendar day following admission to the facility if this is the resident's first stay in the facility or if the resident returns to the facility after being discharged with no expectation of return.** The 14 day calculation does include weekends. When calculating when the RAI is due, the day of admission is counted as day **"0".** For example, if a resident is admitted at 8:30 a.m. on Wednesday, a completed RAI is required by the end of the day Wednesday, two weeks after admission. If a resident dies or is discharged within 14 days of admission, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[3] In closing the record, the facility **may** wish to note why the RAI was not completed. (MDS items that were not completed prior to the day of death or discharge are left blank. [Sections AA, AD (if relevant), and R are signed.] - See **Section 2.5 regarding necessary signatures.)**

**The interdisciplinary team may start and complete the initial assessment at any time prior to the end of the 14th day. If desired by the facility, the MDS could be completed in entirety on the day of admission. However, thii requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident's status during the time periods used to code each MDS item, as opposed to allowing a period for facility observation.; Facilities may find early completion of the MDS and RAPs particularly beneficial for individuals with short lengths of stay, when the assessment and care planning process is oftenaccelerated.**

### EXAMPLES

Miss A. is admitted on Friday, September 1. Staff establish the Assessment Reference Date as September 8, which means that September 8 is the final day of the observation period for all MDS items (i.e.; count back 7 days to determine the period of observation for 7 day items, count back 14 days for 14 day items, and so on). As this is an initial assessment, staff must rely on the resident and family's verbal history and transfer documentation accompanying Miss. A. to complete items requiring longer than a. 7 day period of observation. Staff complete the MDS by September 12 (note that the Assessment Reference Date (A3a) does not need to be the same as the Date RN Assessment Coordinator Signed as Complete (R2b). Staff take an additional 3 days to assess the resident using triggered RAPs and to complete all related documentation, which is noted

[3] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines. e.g., portions of the RAI that are "started" must be saved.

as a date field that accompanies the signature of the RN Coordinator for the RAP Assessment Process on the RAP Summary form (VB2).

Miss L. is admitted on Monday morning. Staff review the admitting documentation, talk with the physician, and have a brief conversation with her on that day. More information is gathered from the resident and her sister over the next 7 days. In this case, the Assessment Reference Date (A3a) is set as Tuesday of the following week, and observations by all relevant team members are completed as of that date. The MDS and RAPs are completed on Wednesday of that week, nine days after admission, with Wednesday being the date the RN Assessment Coordinator signs off on the MDS (R2b). In this case, Wednesday is also the day the RN Coordinator signs the RAP Summary form as complete (VB2).

If a resident goes to the hospital' and returns during the 14 day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. Otherwise the assessment should be reinitiated and completed within 14 days after readmission, from the hospital. The portion of the resident's record that was previously completed should be stored on the resident's record with a notation that the, assessment was reinitiated because the resident was hospitalized.

Good clinical practice dictates that some MDS items be assessed within the first hours after admission although not necessarily documented at that time (e.g., nutritional status and needs). Other MDS items can best be observed with the passage of time (e.g., resident or staff interaction patterns). The resident's needs will dictate the order and manner in which the interdiiciplii team proceeds throughout the assessment. For example, if a new resident is admitted short of breath and hypotensive, it is imperative to conduct an assessment of the resident's acute cardiorespiratory needs. Likewise, a new resident who is angry with his or her family for admitting him or her to the nursing home, and is actively grieving over losses, will benefit from an early assessment of Customary Routine, Psychosocial Well-Being, and Depression, Anxiety, Sad Mood MDS items.

## ANNUAL REASSESSMENTS

The annual RAI reassessment must be completed within 12 months of the most recent full assessment. The annual reassessment may be initiated at any point prior to the end of the l-year follow-up date, but must be completed by the end of the 365th calendar day after the most recent full RAI assessment (i.e., the date the RN Coordinator has certified the completion of the assessment on the RAP Summary form under VB2). If a significant change reassessment is completed in the interim, the clock "restarts," with the next assessment due within 365 days of the significant change reassessment. Routinely scheduled RAI assessments may be scheduled early if a facility wants to stagger due dates for assessments.

## SIGNIFICANT CHANGE IN STATUS ASSESSMENTS

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident's condition they should share this information with the resident's physician, who they may consult about the permanency of change. The facility's medical director may also be consulted when differences of opinion about a resident's status occur among team members.

**Document the initial identification of a significant change in terms of the resident' clinical status in the progress notes. Complete a full comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change has occurred.**

A **"significant change" is** defmed as a major change in the resident's status that:

1. **Is not self-limiting**
2. **Impacts on more than one area of the resident's health status; and**
3. **Requires interdisciplinary review or revision of the care plan.**

A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions. For example, normally 'a 5% unplanned weight loss would trigger a "significant change" reassessment. (See **GUIDELINES FOR DETERMINING CHANGE IN RESIDENT STATUS below.)** However, if a resident had the flu and experienced nausea and diarrhea for a week, a 5 % weight loss may be an expected outcome. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity. of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff should begin a comprehensive RAI assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

Other conditions may not be permanent but would have such an impact on the resident's overall status that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect the resident's functional capacity and day to day routine should be investigated in a holistic manner through the

RAI reassessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent" but a change does not need to be both major and permanent.

**A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes** within a particular domain (e.g., two areas of ADL decline or improvement). Any determination about whether a resident has experienced a significant change in status is a **clinical** decision.

**GUIDELINES FOR DETERMINING SIGNIFICANT CHANGE IN RESIDENT STATUS. (Please note this is not an exhaustive list.)**

**Decline:**

- Resident's decision making changes from 0 or 1 to 2 or 3 for B4 of the MDS;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (E2 of the MDS);
- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1"s for E4B 'of the MDS);
- Any decline in an ADL physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) for G1A of the MDS;
- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 (H1a or b of the MDS), or there was placement of an indwelling catheter (H3d of the MDS);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (K3a of the MDS);
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher (M2a of the MDS);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (P4c and e of the MDS);
- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making) (item Q2 = 2 on the MDS);
- Emergence of a condition or disease in which a resident is judged to be unstable (item J5a on the MDS).

EXAMPLE

Mr. T. no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change and reassessment 'is required since there has been a deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Mr. T.'s behavioral symptoms could have many causes, and reassessment will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T.'s disruptive behavior.

Improvement

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (G1A of the MDS);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (E2 and E4B of the MDS);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (B4 of the MDS);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (H1a or b of the MDS);
- Overall improvement of resident's condition; resident receives fewer supports (item Q2 = 1 on the MDS).

EXAMPLE

Mrs. G. has been in the facility for 5 weeks, following an 8 week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or agitated. All concerned - the resident, her family, and staff - agree that she has made remarkable progress. A reassessment is required at this time. The resident is not the person she was at admission; her initial problems have resolved. Reassessment will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

While a facility may choose to perform more frequent comprehensive assessments than mandated by HCFA, reassessments are not required for minor, or temporary variations in resident status. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary clinical interventions, even though a reassessment

is not required. In these cases the resident's condition is expected to return to baseline within a short period of time, such as l-2 weeks.

GUIDELINES FOR WHEN A CHANGE IN RESIDENT STATUS **IS NOT SIGNIFICANT** (Please note this is not an exhaustive list)

- Discrete and easily reversible cause(s) documented in the resident's record and for which the interdisciplinary team can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a significant change reassessment).

- Short-term acute illness such as a mild fever secondary to a cold from which the interdisciplinary team expects the resident to fully recover.

- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a significant change assessment).

- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.

- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

- 'In an end-stage disease status, a full reassessment is optional, depending on a clinical determination of whether the resident would benefit from it. The facility is still responsible for providing necessary care and services to assist the resident to achieve his or her highest practicable well-being. However, provided that the facility identifies and responds to problems and needs associated with the terminal condition, a comprehensive re-assessment is not necessarily indicated. (Documented at item J5c on the resident's most current MDS.)

**EXAMPLES**

Mr. M. has been in this facility for two and one-half years. He has been a favorite of staff and other residents and his daughter has been an active volunteer on the unit. Mr. M. is now in the end stage of his course of chronic dementia — diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family are fully aware of his status. He is on a special dementia unit, staffhave detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff have responded in a timely, appropriate manner. In this case, Mr. M.'s care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new **MDS** assessment for this bedbound, highly dependent terminal resident.

Mrs. K. came into the facility with identifiable problems and has steadily responded to treatment. Her conditionhas improved over time and plateaued. She will be discharged within 5 days. The initial RAI helped to set goals and start care. Care was modified as necessary to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A reassessment need not be Completed in view of the imminent discharge. **Remember, facilities have 14 days to complete a reassessment once the resident's condition has stabilized, and if Mrs. K. is discharged within this period, a new assessment is not required. If the resident's discharge** plans **change or if she is not discharged, a reassessment is required by the end of the allotted 14 day period.**

**Mrs.** P., too, has responded to care. Unlike Mrs. K., however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff are on top of the situation, and there is nothing to be gained by requiring an MDS reassessment at this time. However, if her condition were to stabilize and her discharge was not imminent, a reassessment would be in order.

## ASSESSMENTS ON RETURN STAY/READMISSION

If a facility has discharged a resident without the expectation that the resident would return, then the returning resident is considered a new admission (return stay) and would require an initial admission RAI comprehensive assessment including Sections AB (Demographic Information) and AC (Customary Routine) within 14 days of admission.

If a resident returns to a facility following a temporary absence for hospitalization or therapeutic **leave, it is considered a readmission. Facilities are not required to assess a resident if they are** readmitted, unless a significant change in the resident's condition has occurred. In these situations follow the procedures for significant change assessments. (See **SIGNIFICANT CHANGE IN STATUS ASSESSMENTS above.)** It is not necessary to complete Sections AB (Demographic

Information) or AC (Customary Routine) of the MDS if this information has previously been collected and entered into the resident's record.

## QUARTERLY ASSESSMENTS

The Quarterly Assessment is used to track resident status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, **three quarterly reviews and one full assessment are required in each 12 month period.**

Although a review of **key mandated items is required in each 3 month period,** facilities may vary or stagger their schedules (e.g., a facility may choose to review all residents in February, May, August and November, while another facility may choose to stagger their quarterly assessments for residents by reviewing some in January, others in February and the remainder in March, with the first group reviewed again in April).

The resident's status must be assessed for each of the key mandated **items of the** Quarterly Assessment using the State-specified form. There is now a mandated form from HCFA,[4] which must be used for all quarterly assessments, unless your State has specified another form. In conducting Quarterly Assessments, facilities must also assess any additional items required for use by the State. Based on the Quarterly Assessment, the resident's care plan is revised if necessary. Once Federal or State computerization requirements are effective, facilities must complete Section AA, Identification Information on the Basic Assessment Tracking form, as well as the items listed in the table below:

[4] HCFA's Quarterly Assessment Form is found in Appendix B. A three-page optional Quarterly Assessment Form for use in RUGs-III payment systems may be required by your State (also in Appendix B).

## KEY MANDATED MDS ITEMS FOR QUARTERLY ASSESSMENT

**Section A: Identification and Background Information**

Item 1 - Resident Name
Item 2 - Room Number
Item 3a - Assessment Reference Date
Item 4a - Date of Reentry
Item 6 - Medical Record Number

**Section B: Cognitive Patterns**

Item 1 - Comatose
Item 2 - Memory
Item 4 - Cognitive Skills for Daily Decision-making
Item 5 - Indicators of Delirium-Periodic Disordered Thinking/Awareness

**Section C: Communication/Hearing P&terns**

Item 4 - Making Self Understood
Item 6 - Ability to Understand Others

**Section E: Mood and Behavior Patterns**

Item 1 - Indicators of Depression, Anxiety, Sad Mood
Item 2 - Mood Persistence
Item 4 - Behavioral Symptoms'

**Section G: Physical Functioning and Structural Problems**

Item 1 - ADL Self-Performance
Item2 - Bathing
Item4 - Functional Limitation in Range of Motion
Items 6a, band f - Modes of Transfer

**Section H: Continence in Last 14 Days**

Item 1 - Continence Self-Control
Item 2d and e - Bowel Elimination Pattern
Items 3a, b, c, d, i and j - Appliances and Programs

**Section I: Disease Diagnoses**
- Items 2j and m - Infections
- Item 3. - Other Current Diagnoses and ICD-9 Codes
  (Note only those diseases diagnosed in the last 90 days that have a relationship to curren ADL status, cognitive status, mood and behavior status, medical treatments, nursin monitoring or risk of death.)

**iection J: Health Conditions**
- Items lc, i, and p - Problem Conditions
- Item 2 - Pain Symptoms
- Item 4 - Accidents
- Item 5 - Stability of Conditions

**section K: Oral/Nutritional Status**
- Item 3 - Weight Change
- Items 5b, h, and i - Nutritional Approaches

**Section M: Skin Condition**
- Item 1 - Ulcers
- Item 2 - Type of Ulcer

**Section N: Activity Pursuit Patterns**
- Item 1 - Time Awake
- Item 2 - Average Time Involved in Activities

**Section 0: Medications**
- Item 1 - Number of Medications
- Item 4 - Days Received the Following Medications

**section P: Special Treatments and Procedures**
- Item 4 - Devices and Restraints

**Section Q: Discharge Potential**
- Item 2 - Overall Change in Care Needs

**Section R: Assessment/Discharge Information**
- Item 2 - Signatures of Persons Completing the Assessment

## 2.5 Completion of the RAI Assessment and Certification of Accuracy and Completeness

### PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulation? require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The RAI must be conducted or coordinated by an RN who signs and certifies the completion of the assessment?. If a facility does not. have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the RAI. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physicians evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the MDS and RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to mtegrate the RAI into theii day-today operations. For example, facilities should develop their own policies and procedures to accomplish the following:

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[5] 42 CFR 483.20 (c)(1)(i)--(F 278)

[6] 42 CFR 483.20 (e)(1)(ii)--(F 278)

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.

- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff' nurses, attending physicians, social workers, activities specialists, physical, occupational, or speech therapists, dietitians and pharmacists.

- Assure that residents and their families are actively involved in the information sharing and decision-making processes.

- Assure that the insights of all non-licensed persons who regularly provide direct care to the resident (e.g., nursing assistants, activity aides, volunteers) are included in the assessment process.

- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.

- Instruct staff on how to integrate MDS information with existing facility resident assessment and care planning practices.

## CERTIFYING ACCURACY AND COMPLETENESS

Each individual team member who completes a portion of the assessment must sign and certify its accuracy.[7] Each interdisciplinary team member who completes a portion of the MDS assessment signs; dates, and indicates the portion of the assessment he or she completed. The RN Coordinator is required to sign to certify that the MDS is complete.[8] The RN Coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. If the RN does all of the MDS, then the nurse alone would sign and be responsible for certifying accuracy and completeness.

The RN Coordinator must also sign the RAP Summary form to signify completion of the RAI assessment. For the admission assessment, the RN Coordinator must sign and date the RAP Summary form within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team

[7] 42 CFR 483.20 (c)(2)–(F 278)

[8] 42 CFR 483.20 (c)(1)(ii)–(F 278)

members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner.

It is never permissible to certify or backdate RAI forms for another individual on the interdisciplinary team. If an individual who completed a portion of the MDS is not available to. sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI when these situations occur.

The staff member entering the care planning decision information must also sign and date the RAP Summary form (VB3 and 4). The facility has 7 days after completing the assessment to complete the care plan. The date for entering of the care plan information may be up to 7 days after the RAPs are completed (i.e., the date on which the RN coordinator signed the RAP Summary form to indicate completion of the RAP assessment process - VB2).

## REPRODUCTION OF THE RAI IN THE RESIDENT'S RECORD AND MAINTENANCE OF THE RAI

Facilities are required to produce a hard copy of each RAI (including the MDS and RAP Summary form) conducted on admission, after a significant change in the resident's status, at least annually, as well as intervening quarterly assessments.

Facilities are required to maintain 15 months of assessment data in the resident's active clinical record according to HCFA policy. This includes all MDS forms, RAP Summary forms and Quarterly Assessment Forms as required during the previous 15 month period. Assessment data need not be stored in one binder. Rather, facilities may choose to maintain assessment and care planning information in a separate binder or kardex system, as long as the information is kept in a centralized location and is accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. After the 15 month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable. if requested by clinical staff or State agency Surveyors.

The 15 month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of bed hold policies. When the resident then returns to the facility and is "readmitted", the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15 month requirement for maintenance of the RAI data does not restart with each new admission.

If a facility has an electronic clinical record (i.e., does not maintain any paper records), the facility does not need to maintain a hard copy of the RAI, if the system meets the following minimum criteria:

- The system must maintain 15 months' worth of assessment data according to HCFA policy and must be able to print all assessments for that period upon request;
- The facility must have a back-up system to prevent data loss or damage;
- The information must always be readily available and accessible to staff and surveyors; and
- The system must comply with HCFA requirements for safeguarding the confidentiality of clinical records.[9]

## 12.6 Sources of Information for Comdetion of the RAI

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, information in the resident's record is validated by interacting with the resident and direct care staff.

The following sources of information must be used in completing the RAI. 'Although not required, the review sequence for the assessment process generally follows the order below:

- Review of the resident's record. Depending on whether the assessment is an admission or follow-up assessment, the review could include: preadmission, admission or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60 day period; and a record of medications administered for the prior 30 day period.
- Communication with and observation of the resident.
- Communication with direct-care staff (e.g., nursing assistants, activity aides) from all shifts.
- Communication with licensed professionals (from all disciplines) who have recently observe@, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.
- Communication with the resident's physician.

[9] See confidentiality requirements at 42 CFR 483.75 (n)(4)(i-iii) --F516

- Communication with the resident's family. Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, someone else may be very close to the resident, and the resident may wish that this person be contacted.

## REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

**At admission,** record review includes an examination of notes written in the first 2 weeks (assuming the full 14 day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and RAPs from another nursing home if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

**Subsequent reassessments** should focus on recorded information from earlier MDS assessments and quarterly assessments, written information from the previous 3 month period, and notes made during the prior 30 day period.

**The following are important considerations when reviewing the resident's record:**

- **Review the information documented in the record, keeping in mind the required MDS definitions.** Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly,-accordmg to the MDS, a resident, who stays "dry" with a catheter may be considered continent).

- **Make sure that the information taken from the record covers the same observation period as that specified by the MDS items. The MDS** refers to specific time frames for each item; for example ADL status is based on resident performance over a 7 day period. To ensure uniformity, the MDS has an Assessment Reference Date **(A3a)** that establishes a common reference end-point for all items. **Consequently, it is necessary to pay careful attention to the notes regarding time frame-s for each section of the MDS and also to the Item- by Item instructions in Chapter 3.**

- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets); where

different types of information are maintained in the clinical record; and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items.** A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff& Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a work tool only.

- **As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.**

## COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, an RN can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confiig staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. (See Appendix D for further information on **"Interviewing Techniques".)**

## COMMUNICATION WITH DIRECT CARE STAFF

Direct care staff (e.g., nursing assistants and activity aides) have daily, intimate contact with residents and are often the most reliable source of information aboutthe resident. Direct care staff talk with and listen to the resident. They observe and assist the resident's performance of ADLs

and involvement in activities. They observe the resident's physical, cognitive and psychosocial status daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- Be sure to speak with a person who has first-hand knowledge of the resident. Plan for sufficient time to talk with direct care staff person(s).
- Start by asking about the resident's performance on ADLs and activities. What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.
- Talk with direct care staff across all shifts, if possible. The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

(See Appendix D for further information on "Interviewing Techniques".)

## COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

## COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. At the Quarterly Assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

## COMMUNICATION WITH THE RESIDENT'S FAMILY

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas,

and customary routine prior to first nursing home admission. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. In most instances, family will not be the sole source of information but will supplement information from other sources. The RAI assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

## 2.7 Completing the MDS Form - Coding and Correction of Errors

Utilizing appropriate information gathered from all of the areas discussed in Section 2.6 above, the individual completing the assessment is required to make a best judgment about each item in each section of the MDS form. The MDS is Dart of the medical record and should always be typed or prepared in ink.

**CODING** CONVENTIONS

The following table specifies the coding conventions to be used when preparing the MDS form:

**MDS CODING CONVENTIONS**

- **Each section of the MDS contains one or more items labeled sequentially. For instance, the third item in Section B (Memory/Recall Ability)** is labeled **"B3",** the second item in Section E (Mood Persistence) is labeled **"E2".**

- **Use the following coding conventions to enter information on the MDS form:**

  Use a check mark for white boxes with lower case letters, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences - 'boxes a. - m.).

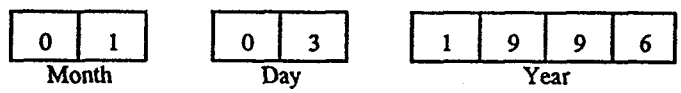
  Use a numeric response (a number or preassigned value) for blank white boxes (e.g., Hla, Bowel Incontinence.)

  Darkly shaded areas remain blank; they are on the form to set off boxes visually.

- **The convention of entering "0": In assigning values for items that have an ordered** set of responses (e.g., from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a **resident** whose ADL codes are almost all coded "0" is a self-sufficient resident; the resident whose ADLs have no "0" codes indicates a resident that receives help from others.

- **USE PRINTED CAPITAL LETTERS to respond** to items that require an **open-**ended response. **Print** legibly (e.g., for "Lifetime Occupations", a line is provided to fill in the resident's previous occupation(s)).

- **Dates -** Where **recording** month, day, and year, enter two digits for the **month** and the day, but four digits for the year. For example, the third day of January in the year 1996 is recorded as :




- **'The standard no-information code is either a "circled" dash or an "NA". This** code indicates that all available sources of information have been **exhausted;** that is the information is **not available, and despite exhaustive probing, it remains unavailable. Although the "circled dash" was originally conceived for use on computerized versions of the MDS, it is also the recommended method of coding on manual forms to "set-off these responses on the forms.**

- **NONE OF ABOVE is a response item to several items (e.g., I2, Infections, box m). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.**

- **"Skip" Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to "skip" over the next item (or several items)** and go on to another (e.g., **B1,** Comatose, directs the assessor to "skip" to Section G. if **B1** is answered "1" - "Yes". **The intervening items from B2 - F3 would not be scored. If B1 was** recorded as "0" - "No", then the assessor **would** continue **with** item B2.).

  A **useful technique** for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" **instructions** before going to the next appropriate item.

- The **"8"** code is for use in Section G., Physical Functioning and Structural Problems **only.** The use of this code is **limited** to situations where the ADL activity was not **performed** and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred **from bed** nor **moved 'between** locations over the entire 7 day period of observation. When the "8" code is entered for **self-performance,** it should also be entered for support.

## CORRECTION OF ERRORS

Facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the nursing home stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of .the facility's responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident's status is not required unless the resident has had a significant change in **status (See Section** 2.4 **for information on Significant Change in Status Assessments).**

**The following procedures apply to the correction of errors in either paper or automated MDS 2.0 systems:**

- Within a paper environment, facilities should "close" the MDS within regulatory time frames (i.e., within 14 days after admission, etc.). This is done by having the RN Coordinator sign and date the MDS at R2a and b. Amendments may be made **to any items during the next 7 day period, provided that the same Assessment Reference Date is used (A3a).** To make revisions, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

- **The concept of "factual errors," which allowed for "correction" of the paper form in certain instances at any time, has been eliminated.** Facilities operating in computerized **States** should seek guidance on State specific policies related to "key changes" and transmission of data for payment purposes.

**The following procedures apply when a facility's MDS data are computerized[10]:**

1. The clinical assessment process must be completed within the standard time frames (i.e., within 14 days after admission, etc.).

2. After completing the clinical assessment process, the facility has the next 7 days to encode the MDS in a computerized file, ensure that all MDS items pass HCFA/State edits[11] and to

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[10] A number of States have already established automated systems and State specific requirements. These States are encouraged to modify their existing systems to conform to the above HCFA policies. However, until national specifications are established, facilities should contact their State regarding State specific requirements. HCFA is currently in the process of developing additional policies for computerization at both the facility and State level. These policies are expected to go into effect sometime in 1996.

[11] HCFA edits should be incorporated in all software products and are available to vendors and facilities through a World Wide Web site accessed through the Internet. Its address is: http://linear.chsra.wisc.edu/mds_info.htm. Vendors and facilities should also contact their State for any specific requirements.

"lock" the computer record. "Locking" the record means that no changes can be made to the MDS (i.e., either paper or electronic versions).

- Encoding process: The facility is responsible for verifying. that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during this 7 day period.

- Editing process: The facility is responsible for running encoded MDS data against HCFA and State specific edits (which all software vendors are responsible for building into MDS Version 2.0 computer systems). For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7 day period, the facility may "correct" item responses in order to meet edits. An assessment is considered complete only if 100% of the required edits arc passed. For "corrected" items, the facility must use the same "period of observation" as that used for the original item completion (i.e., the same Assessment Reference Date- A3a). Any corrections must be accurately reflected in both the electronic and paper copies of the MDS (i.e., the paper version of the MDS must be corrected).

- "Locking" process: After passing the edits, a record is then "locked." Individual MDS records must pass 100% of the edits for the record to be "locked."[12] At this point, the record cannot be changed by the facility.

After the MDS is "locked," the facility may come to realize that items in the "locked" assessment (paper or electronic versions) are in error. The facility may come to such knowledge on its own or it may have been notified by the State that the assessment record failed edits or failed other reviews at the State level. In any event, the record is "locked" and cannot be changed. The facility then has the following options:

1. A new comprehensive "significant change in status" assessment would be performed (i.e, the full MDS and RAPs) if both of the following conditions are met:

   (1) The assessment in error is the most recent assessment; and

   (2) A significant change has actually occurred (i.e., there has been a significant change in the resident's clinical status between the time of the original assessment and the time of the new assessment).

   In this case, there has been a change in the resident's status that meets the Significant Change guidelines and a new comprehensive assessment is therefore required. However, the original assessment was also in error. This new assessment requires a new observation period, a new Assessment Reference Date (A3a), and "significant change in status

[12] "Locked" records will be transferred to the State within a time frame to be determined by HCFA/State policy, pending publication of HCFA's final rule on computerization.

assessment" is coded as the reason for assessment (AA8a = 3). The "Previous Record Date"[13] in the Control Section of the new MDS record must contain the Assessment Reference Date from the original assessment that was in error.

2. If a "significant change in status" has not occurred clinically but the erroneous data in the prior MDS is major enough to warrant correction, then the facility may optionally choose. to perform a new comprehensive "significant correction of prior assessment" if both of the following conditions are satisfied:

   (1) The assessment in error is the most recent assessment; and

   (2) The resident did not experience an actual "significant change in status" between the time of the original assessment and the new comprehensive assessment. However, the resident's clinical condition is different from that depicted in the assessment in error and it would otherwise appear that there had been a significant change-in status.

   If the facility chooses to perform a "significant correction" assessment, then a new MDS and RAPs are required,[14] with the new MDS performed using a new observation period (i.e., a new Assessment Reference Date (A3a)), "significant correction of prior assessment" is coded as the reason for assessment (AA8a = 4), and the "Previous Record Date" in the Control Section of the new MDS record must contain the Assessment Reference Date from the original assessment that was in error.

## 12.8 RAPs and Care Plan Completion

### RAPs

After completing the MDS portion of the RAI assessment, the assessor(s) then proceed to further identify and evaluate the resident's strengths, problems, and needs through use of the **Resident Assessment Protocol Guidelines (RAPs)** described in detail in Chapter 4 of this manual and through further investigation of any resident-specific issues not addressed in the RAI.

**Completed along with the MDS, the RAPs provide the foundation upon which the care plan is formulated.** There are 18 problem-oriented RAPs, each of which include MDS-based "trigger" conditions that signal, the need for additional assessment and review. Triggers and their definitions for each RAP appear in **Appendii C. Also in Appendix C** are the RAP Guidelines

[13]The "Control Section" is part of the standardized record layout made available to facilities and vendors for development and programming of MDS data systems. It provides information that will be used when the MDS data is transferred from the facility to the State. It is not a part of the clinical MDS form.

[14]New RAPs are required because the prior inaccurate description of the resident could have misguided staff in the triggering and problem identification activities_

for additional assessment and review to determine if a care plan is appropriate to address the triggered condition.

The triggers and their definitions should provide facility staff with information to better understand the underlying cause of a problem. Often staff may be aware that a problem, warranting care planning, exists before reviewing the RAP Guidelines for a triggered condition. The Guidelines should help staff to identify the factors that have caused the resident's problem and provide direction as to what additional information is needed about the resident's problem. After **reviewing triggered RAPs, the RAP Summary form is used to document decisions about care planning and to specify where key information from the assessment for triggered RAP conditions is noted in the record.**

LINEAGE OF MDS AND RAPS TO FORMULATION OF THE CARE PLAN

**For an admission (initial) assessment, the resident enters the facility on day 1 with a set** of physician-based treatment orders. Facility staff typically review these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, around which significant segments of the care plan is constructed.

On day 1, facility staff also begin to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determine whether there are problems that require. immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing home). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The MDS and RAPs provide the clinician with additional information to assist in this preliminary care planning process. The MDS ensures that staff have timely access to a wide range of assessment data. The RAPs provide criteria that trigger review of possible problem conditions to ensure that staff identify problems in a consistent and systematic manner. Use of the RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission MDS is not completed until the last date possible (i.e., at the end of calendar day 14 of the residency period), interventions will already have been implemented to address priority problems. Many of the appropriate RAP problems will have been identified, causes will have been considered, and a prelimii care plan initiated. The final written care plan, however, is not required until 7 days after the RAI assessment is completed.

**For triggered problems that have already resulted in a care plan intervention, the final RAP review will ensure that all causal factors have been considered. For RAP conditions for which facility staff have not yet initiated a care program, the RAP review will focus on whether these conditions are, in fact, problems that require facility intervention.** For any triggered problem, staff will apply the RAP Guidelines to evaluate the resident's status and

determine whether a situation exists that warrants care planning. If it does, the RAP Guidelines will next be used to help identify the factors that should be considered for developing the care plan.

For **an Annual reassessment or a Significant Change in Status assessment, the process is basically the same as that described** for newly admitted residents. In these cases, however, the **care** plan will already be in place, and staff are unlikely to be actively instituting a new approach to care as they simultaneously complete the MDS and RAPs. Here, review of the RAPs when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the RAP may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

CARE PLAN COMPLETION

Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident's care plan. The RN coordinator should sign and date the RAP Summary form **after all triggered RAPs have been reviewed to certify completion of the comprehensive assessment (VB1 and 2). Facilities should use this date to determine the date by which the care plan must be completed.**

The 7 day requirement for completion or modification of the care plan applies to the Admission, Significant Change in Status, or Annual RAI Assessment. A new care plan does not need to be developed after each significant change of status or annual reassessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each quarterly assessment and modify the care plan if necessary. (See **Chapter 5 for more information on Care Planning.)**

# Chapter 3: Item-by-kern Guide to MDS Version 2.0

## 3.1 Mandated Assessments, and Associated Forms

The following rules apply to HCFA's RAI, Version 2.0, as used by all nursing homes certified to participate in Medicare or Medicaid. Copies of all required forms are in Appendix B.

The content of the Minimum Data Set (MDS) Version 2.0 Nursing Home Resident Assessment is recorded on the following mandated forms: [See Appendix B for copies of all forms.]

1. The ***Basic Assessment Tracking Form.*** This form includes Section AA (Identification Information) Items 1-9. This form must be submitted with every ***Full Assessment, Quarterly Assessment,*** and State required assessment. This form provides "key" information necessary to identify and track residents in automated systems.

2. MDS Version 2.0 ***Full Assessment Form. This*** form contains MDS Sections A (Identification and Background Information) through Section R (Assessment Information). The full assessment is to be completed at admission, annually, and at the time of significant change in resident status. The ***Full Assessment is*** required more frequently by States participating in the Nursing Home Case-Mix and Quality Demonstration (NHCMQ) as well as by some other States. Contact your State RAI representative if you have any questions about when assessments are required. Additional items (if any) required by your State may appear in Section S. NHCMQ State-required material appears in Sections T and U.

   - ***Background (Face Sheet) Information at Admission. This*** form contains MDS Section AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This form is to be completed at the time of the resident's initial admission to the nursing home.

3. MDS Version 2.0 ***Quarterly Assessment Form.*** This form contains a mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information). This form is to be completed no less frequently than once every three months between annual full assessments. Some States have mandated an expanded ***Quarterly Assessment Form,*** such as the optional version for RUG III found in Appendix B.

4. ***RAP Summary Form.*** Considered Section V of the MDS, this form is used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether a care plan has been developed for

the triggered RAP. A ***Rap Summary Form*** must be completed each time an RAI is required (Le., under the Federal schedule, each tie a full MDS is completed).*

With MDS Version 2.0, two new forms have been developed for future use in each nursing home's computerized information system to track each resident's "whereabouts" in the health care system. Once HCFA's MDS computerization requirement is in place, facilities shall use these forms. Each of these tracking forms contain Section AA (Identification Information) Items1 through 7, and a subset of codes from Item 8, Reason for Assessment. In a computerized information system, MDS Items AA1 through 7 need to be completed only once (at admission) and saved in the system files. However, this identification information must be verified prior to "closing" the assessment record for each subsequent assessment. For each discharge from or reentry to the nursing home, it is anticipated that nursing home staff (e.g., clerk) will record the move in Item AA8, Reason for Assessment. The computer will then generate the appropriate information to accompany the type of assessment being completed. The following-two forms are included in this resident tracking system:

1. ***The Discharge Tracking Form.*** This form includes Section AA (Identification Information) Items l-9, but only the 3 discharge codes from Item 8, Reason for Assessment, It also contains Items AB1-2, A6, and R3-4. In a computerized system, this form must be completed whenever a resident is discharged from the facility for reasons other than a temporary visit home. This is the only form that must always be completed at the time of any discharge from the nursing home. The following is the only condition when other forms shall accompany the ***Discharge Tracking Form:***

   - If the resident was discharged for any reason within 14 days of admission and you were able to complete a ***Full Assessment Form*** before the resident was discharged, the resident's MDS computerized file would contain a ***Basic Assessment Form,*** a ***Background (Face Sheet) Information at Admission Form,*** a ***Full Assessment Form,*** and a ***Discharge Tracking Form. In this scenario,*** enter a code of "1" Admission Assessment (required by day 14) for Item 8 (Reason for Assessment) on both the***Basic Assessment Form*** and the ***Full Assessment Form;*** enter a code of either "6" Discharged-return not anticipated, or "7" Discharged (return anticipated) as appropriate, for Item 8 onthe ***Discharge Trucking Form.***

2. The ***Reentry Tracking Form.*** This form includes Section AA (Identification Information) Items l-9, but only one code (ie., code designating Reentry) from Item 8, Reason for Assessment. It also contains items A4a and b, and 6. In a computerized system, this form is completed whenever a resident reenters the nursing home following temporary admission to a hospital or other health care setting. This is the only form that must always be completed at the time of reentry to the nursing home. The following is the only condition when other forms shall accompany a ***Reentry Tracking Form:***

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'Some States require completion of the full MDS each quarter or more frequently for payment purposes. The RAP Summary Form does not need to be completed on these occasions.

- If the resident reenters the nursing home following a temporary admission to a hospital or other health care setting AND also meets significant change criteria, a ***Full Assessment*** must be completed. In this case, the resident's file should contain a ***Reentry Trucking Form,*** a ***Basic Assessment Tracking Form,*** and a ***Full Assessment*** (significant change). In this scenario, enter a code of **"9"** Reentry for Item 8 (Reason for Assessment) on the, Reentry Tracking Form; enter a code of "3" Significant Change Assessment for Item 8 (Reason for Assessment) on both the ***Basic Assessment Tracking Form*** **and the** ***Full Assessment*** form. Completion of a ***Full Assessment*** may also be required by the State.

## 3.2 Overview to the Item-by-Item Guide to MDS Version 2.0 1

This Chapter is to be used in conjunction with Version 2.0 of the MDS, which can be found in Chapter 1 beginning on page l-6 and in Appendix B. Also includes in this chapter are the instructions for the supplemental items in MDS Sections S and T used in the NHCMQ demonstration States.

The changes in Version 2.0 of HCFA's MDS were made in response to comments and suggestions regarding the first version of the MDS. They were received from the nursing home industry, health professionals, advocacy groups, surveyors, etc. A few items were dropped, others modified, and still others added. This chapter includes significant new material, many more examples, and refined definitions, as compared to HCFA's original RAI Training Manual that was published in December 1990.

**This** chapter provides information to facilitate an **accurate and uniform resident** assessment. **Item-by-item instructions focus on:**

- The intent of items included on the MDS.
- Supplemental definitions and instructions for completing MDS items.
- Reminders of which MDS items require observation of the resident for other than the standard 7day observation period.
- Sources of information to be consulted in completing specific MDS items.

## 3.3 How Can This Chapter be Used?

**Use this chapter alongside the MDS Version 2.0 form, keeping the form in front of you at** all times. The MDS form itself contains a wealth of information. Learn to rely on it for many of the definitions and procedural instructions necessary for good assessment. The amplifying information in this chapter should facilitate successful use of the MDS form. The items from the

MDS forms are presented in a sequential basis in this chapter. Where items are presented on a form other than the full MDS assessment form, this fact is noted in the text.

***The chart that follows summarizes the recommended approach to assist you in becoming familiar with MDS Version 2.0. The initial time investment in this multi-step review process will have a major payback.***

If you are familiar with the MDS and are reviewing this Chapter for new items that appear in Version 2.0 of the MDS, review the MDS form beginning on page l-6 of Chapter 1 for new items.

New materials of the following types are presented in this Chapter: Item definitions, examples, and process recommendations regarding how to complete the assessment. Thus, you will fmd much useful new information regarding many of the items that were in the original MDS.

## Recommended Approach for Becoming Familiar with the MDS

**A)** First, **review the MDS form itself.**

- **Notice** how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions.
- Are ***the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?***
- Complete the MDS assessment for a resident at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS form. Where your review could benefit from additional information, make note of that fact. ***Where might you secure additional information?***

**(Continued on next page)**

## Recommended Approach for Becoming Familiar with the MDS (Continued)

**(B) Complete the initial pass through this chapter.**

- **Go on to this** step only after **first** reviewing the MDS form and trying to complete all items for a resident who is well known to you.
- As you read this **chapter,** clarify questions that arose as you used the MDS for the first time to assess a resident. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- ***Once again, read the instructions that apply to a single section of the MDS. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same? It will tie time to go through all this material. Do it slowly. Do not rush. Work through the Manual one section at a time.***
- ***Are you surprised by any MDS definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?***
- ***Do any definitions or instructions differ from what you thought you learned when you reviewed the MDS form?***
- ***Would you now complete your initial case differently?***
- ***Are there definitions or instructions that differ from current practice patterns in your facility?***
- Make notations next to **any** section(s) of this Manual you have questions about. Be prepared to discuss **these** issues during any formal training program you attend, or contact your State MDS **resource** person (see Appendix A).
- Read and complete the test cases at the end of this chapter.

**(Continued on next page)**

## Recommended Approach for Becoming Familiar with the MDS (Continued)

**In a second pass through this chapter, focus on issues that were more difficult or problematic in the first pass.**

- **Make notes on the MDS form of issues** that warrant attention.
- **Further familiarize** yourself with definitions and procedures that diier from **current** practice **patterns** or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.

**(D)** The **third pass through this chapter may occur during the formal MDS training program at your facility** and will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

**(E) Future use of information in this chapter:**

- Keep this chapter at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- **This** Manual **is** a source of information. Use it to increase the accuracy of your assessments.

## 3.4 What is the Standard Format Used in this Chapter?

To facilitate completion of Version 2.0 of the MDS assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many (but not all) items:

***Intent:*** Reason(s) for including the item (or set of items) in the MDS, including discussions of how the information will be used by clinical staff to identify resident problems and develop the plan of care.

***Definition:*** Explanation of key terms.

***Process:*** Sources of information and methods for determining the correct 'response for an item. Sources include:

- Discussion with facility staff — licensed and nonlicensed staff members
- Resident interview and observation
- Clinical records, facility records, transmittal records (at admission) — physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g., vital signs, weights, intake and output), care plans, and any similar documents in the facility record system
- Discussion with the resident's family
- Attending physician.

***Coding:*** Proper method of recording each response, with explanations of individual response categories.

## 3.5 Item-by-Item Instructions for the MDS Form

This section of item-by-item instructions follows the sequence of items on the HCFA MDS, Version 2.0. Notice that an MDS section designation appears at the top of the pages that follow; this will facilitate your use of this chapter as a reference tool in the future.

# IDENTIFICATION INFORMATION SECTION AA

**This section** provides the key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment. A copy of this form must accompany each Full or Quarterly Assessment submitted for computer entry in a State or Federal archiving system.

## AA. IDENTIFICATION INFORMATION

### 1. Resident Name

*Definition:* Legal name in record.

*Coding:* 'Use printed letters. Enter in the following order — a.) first name, b.) middle initial, c.) last name, d.) Jr./Sr. If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item (b) blank.

### 2. Gender

*Coding:* Enter "1" for Male or "2" for Female.

### 3. Birth date

*Coding:* *Fii in* the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:

| 0 | 1 | | 0 | 2 | | 1 | 9 | 1 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

## 4. Race/Ethnic@

***Process:*** Enter the race or ethnic category the resident uses to identify him- or herself. Consult the resident, as necessary. For example, if parents are of two different races, consult with resident to determine how he or she wishes to he classified.

***Coding:*** 'Choose only one answer.

## 5. Social Security and Medicare Numbers

***Intent:*** To record resident identifier numbers.

***Process:*** Review the resident's record. If these numbers are missing, consult with your facility's business office.

***. &ding:*** Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

**Social Security Number —** If no Social Security number is available for the resident (e.g., if the resident is a recent immigrant or a child), enter the standard "no information" code, "NA" or a circled dash ⊖.

Medicare number **(or** comparable railroad insurance number) — Approximately 98% of persons age 65 or older have a Medicare number. Enter the resident's Medicare number. This number occasionally changes with marital status. If a question arises, check with your facility's business office or social worker.

In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, place a "C" in the-left most Medicare Number box, and continue entering the number itself, one digit per box, beginning with the second box.

## 6. Facility Provider Numbers

***Intent:*** To record the facility identifier numbers.

***Definition:*** The identification numbers assigned to the nursing home by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. Medicaid only facilities have a Federal as well as a State number. The Medicaid Federal number has a "letter" in the third box.

Process: You can obtain the facility's Medicare and Medicaid numbers from the facility's business office. Once you have these numbers, they apply to all residents of that facility.

*Coding:* Begin writing in the left-hand box. Enter one digit per box. Recheck the number to be sure you have entered the digits correctly. There must be at least one type of facility number entered, but there may be more than one.

## 7. Medicaid Number (if applicable)

*Coding:* Record this number if the resident is a Medicaid recipient. Begin writing one number per box in the left hand box. Recheck the number to make sure you have entered the digits correctly. Enter a ***"+" in the left most box if the number is pending. If not applicable because the, resident is not a Medicaid recipient, enter "N" in the left most box.***

## 8. Reasons for Assessment [This item also appears and must be completed on the MDS Full Assessment Form, Section A, Item 8.]

a. Primary Reason for Assessment

***Intent:*** To document the reason for completing the assessment using the various categories of assessment types mandated by Federal regulation. Most of the types of assessments listed below will require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the MDS and RAPs. [Note — assessment type 5, the Quarterly review assessment, requires you to complete only a limited number of MDS items — see Appendix B for the Quarterly Assessment Form.] Please note that it is possible to select a code from both 8a (Primary reason for assessment) and 8b (Special codes).

***Minimum Discharge Assessment Requirement.*** With the release of Version 2.0 of the MDS, a minimal list of MDS items must be completed for all discharges and facility reentries in States that are automated. These items are referenced on their own forms and item 8 (Reason for Assessment) also appears on these forms. It is listed as Item 8a in Section AA of the ***Discharge Tracking*** and ***Reentry Tracking Form*** and Item AA8a on the *Identification* ***Information Form.***

***Definition:*** **1. Admiiion assessment_ A comprehensive assessment using the MDS and RAPs** required by day 14 of the resident's stay. [Note — this code is used if resident is being readmitted subsequent to a discharge where return was not anticipated_]

2. Annual assessment — A comprehensive reassessment required within 12 months of **the** most recent full assessment. If significant change is noted, **code** "3" (significant change in status assessment). DO NOT code as an **Annual** assessment.

3. **Significant change in status assessment** — A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's **clinical** status, and that requires **interdisciplinary** review or revision of the care plan to ensure that appropriate care is given. **When** there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. -See **procedure described later in this chapter under item A8 for assessing whether a significant change (either improvement or decline) has occurred.**

4. **Significant correction of prior assessment -A comprehensive assessment** completed at the facility's prerogative, **because** the previous assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which there has **been** an actual change in the resident's health status.

5. **Quarterly Review Assessment -The subset** of MDS items specified on HCFA's Quarterly ***Assessment Form,*** which **must** be completed no less frequently than. once every 3 months (i.e., between **required** full assessments). This assessment ensures that the care plan is correct and up to date. It also should identify **instances** where significant changes in resident status have occurred. If a significant change is noted, use Code "3" (Significant change in status assessment). DO NOT CODE as a Quarterly review assessment.

6. **Discharged — return not anticipated — [This is** not a code used on this **form;it is used on the *Discharge Tracking Form only.]*** Use this code when a resident is permanently discharged **from** a nursing home. This provides a means of "closing" the record of any resident at the point of discharge from the facility (without an anticipated return). Note — until HCFA's **ADP** requirement **is** effective, this code is **used** only in nursing homes that are required to submit data to the State.

7. Discharged — **return anticipated — [This is not a code used** on **this** form, it is used on the ***Discharge Tracking Form only.]*** Use this code when a resident is temporally discharged to a hospital (or other therapeutic setting). Note — until **HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

8. Discharged prior to completing initial assessment — [This is not a code used on this form, it is used on ***the Discharge Tracking Form*** only.] Use this code when a resident is discharged during the first 14 days of residency AND the MDS assessment remains incomplete. A subset of information is entered for all residents regardless of length of stay. ***Even a very short stay resident (e.g., a person who stayed for even one day) must be tracked by the MDS system.*** At the same time, remember that you have **14** days to complete the full MDS admission assessment, and by using this code you are identifying residents who have been discharged, transferred or died prior to day 14, thereby prohibiting your completion of a full assessment. Note — until HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.

9. Reentry — [This is not a code used on this form; it is used on the ***Reentry Form only.] Use this code*** when a resident of your facility is readmitted from a temporary discharge to a hospital or other therapeutic setting (other than for a therapuetic leave). Note — until HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.

0. NONE OF ABOVE — Use this code when your state requires you to complete one of the additional assessment types referenced in Item AA8b (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., Case-Mix payment). Select the code under item b (below) that indicates the primary reason for assessment.

b. Special codes for use with supplemental assessment types in Case-Mix Demonstration States or other States where required. It is possible to select a code from both 8a and 8b (e.g., Item 8a coded "3" (Significant Change in Status assessment), and Item 8b coded "3" (60day assessment).

1. 5 day assessment — Required for payment reason prior to the Federally mandated admission assessment required by day 14 (Code 1,. for item a).

2. ***30*** day assessment

3. ***60*** day assessment — In following this cycle of assessments, the initial Quarterly review assessment would be due at 90 days.

4. Quarterly assessment using full MDS form — Assessment completed within a 3-month interval from the last assessment, using a full (not quarterly) MDS assessment form as required by the State or NHCMQ demonstration. For Case-Mix Demonstration States, the initial Quarterly

Assessment would be due at 90' days after admission, in addition to completion of the 60-day assessment.

5. Readmission/return assessment -- A full reassessment (i.e., MDS and RAPs) required only for residents in NHCMQ demonstration facilities (or as required by the State) who are hospitalized for more than 72 hours, or who are discharged and later readmitted to the facility from the hospital.

6. Other state required assessment -- An example is a Utilization Review assessment. 'States may issue additional instructions.

Example

Mr. X resides in a nursing home in Kansas, a Case-Mix Demonstration State. He was admitted to the nursing home from an acute care hospital on 1/20/95. At the time of the admission assessment, he still exhibited some signs of delirium that had begun post-operatively in the hospital. Functionally he required extensive assistance with all ADLs. It is now time for his 60-day assessment. Cognitively, Mr. X's confusion has cleared to the point that the decisions he makes are now consistent and reasonable. His ADL performance has improved in all areas; he is either independent .or receives some supervision.

*Coding:* Enter the number corresponding to the primary reason for assessment. For item a (Primary reason for assessment), for codes l-9, leave first box blank, placing correct digit in the second box.

## 9. Signatures of Persons Completing These Items

*Coding:* Staff who completed parts of Section AA. Identification Information must enter their signatures, titles, and date they completed the section.

# BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION SECTIONS AB, AC, AD

# AB. DEMOGRAPHIC INFORMATION

## 1. Date of Entry

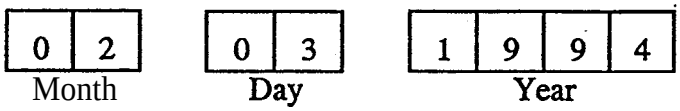
*Intent:* **Normally, the MDS** Face Sheet (Sections AB and AC) is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering your facility after a **discharge** where return had not previously been expected. Do not complete the face sheet following temporary discharges to hospitals or after therapeutic leaves/home visits. ***Given this definition, enter the date the person first became a resident/patient in your facility.***

Admission and "bed-hold" policies vary among nursing homes across the country. Likewise, the way in which facilities "open" and "close" resident's medical records also varies. Some facilities choose to "close" a record when a resident is transferred for an overnight stay at an acute care hospital? and "open" a new record when the resident returns to the nursing facility. Other nursing homes maintain the resident's clinical record as open (current) even when the resident is transferred for a temporary hospital stay. For MDS purposes, the date of entry is the date the resident entered the facility for care, **regardless** of **how the facility chooses to "open" or "close" its medical** records during the course of the stay.

*Definition:* Date the stay began — The date the resident was most recently admitted to your facility. For example: if the resident was **officially** discharged in the past without the expectation of return (e.g., diiharged home or to another nursing facility), enter the most recent admission date. However, if your facility begins a new record on each return from a temporary hospital stay or temporary leave, you will complete the face sheet only at the original assessment. Do not complete the face sheet at **the** time of return from a temporary leave, even if you are required to complete the remainder of the form (e.g., a significant change assessment is required).

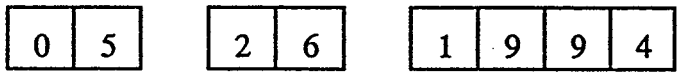
*Process:* Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at your facility.

*Coding:* ***Use all boxes.*** For a one-digit month or day, place a zero in the first box. For example: February 3, 1994, should be entered as:




Example

Mrs. F, a diabetic, had been living with her daughter when she fractured her left hip during a fall off a footstool. She spent a few days in the local hospital after surgery, followed by an admission to a nursing facility on **5/26/94** for rehabilitation. Three weeks later **(6/16/94),** Mrs. F was transferred back to the hospital for an infected incision site over her left hip and general state of decline. Mrs. F returned to the nursing home eight days later. In this instance, code the following date on the original face sheet.




Rationale: The face sheet sections of the **MDS — AB** and AC are completed **only** when the resident first becomes a resident of the facility. In this case there is no need to complete a new face sheet upon return readmission from a temporary hospital stay where the resident is expected to return to the nursing home.

## 2. Admitted From (At Entry)

*Intent:* To facilitate care planning by documenting the place from which the resident was admitted to the nursing home on the date given in item **AB1.** For example, if the admission was from an acute care hospital, an immediate review of current medications might be warranted since the-resident could be at a higher risk for delirium or may be recovering from delirium associated with acute **illness,** medications or anesthesia. Or, if admission was from home, the resident could be grieving due to losses **associated with** giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

*Definition:* **Private** home **or** apartment — Any house, condominium, or apartment in the community whether owned by the resident or **another.** person. Also included **in this** category are retirement communities, and independent housing for the elderly.

Home health services — Includes skilled nursing, **therapy (e.g.,** physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

Assisted Living — A non-institutional community residential setting that includes services of the following types: . home health services, homemaker/personal care services, or meal services.

Other — Includes hospices and chronic disease. hospitals.

*Process:* Review admission records. Consult the resident and the resident's family.

*Coding:* Choose only one answer.

Example

Mr. F, who had been living in his own home with his wife, was admitted to an acute care hospital with a CVA. From the hospital, Mr. F was transferred to this nursing home for rehabilitation. Because Mr. F was admitted to your facility from the acute care hospital, **"5"** is the appropriate code.

## 3. Lived Alone (Prior to Entry)

*Intent:* To document the resident's living arrangements prior to admission.

*Definition:* In other facility — Any institutional/supportive setting, such as a nursing home, group home, sheltered care, board and care home.

*Process:* Review admission records. Consult the resident and the resident's family.

*Coding:* If living in another facility (i-e., nursing facility, group home, board and care, assisted living) prior to admission to the nursing home, enter "2".

If the resident was not living in another facility prior to admission to the nursing home, enter "0" or "1", as appropriate.

Examples

- Mrs. H lived on her own and her daughters took turns sleeping in her home so she would never be alone at night. **Code "0" for No (did not live alone).** If, however, her daughters stayed with her only 3-4 nights per week, **Code "1" for Yes (lived alone).**
- Mr. J lived in his own second-floor apartment of a two-family home and received constant attention from his family, who lived on the first floor. **Code "0" for** No **(did not live alone).**
- Mr. D lived with his wife in housing for the elderly prior to admission. **Code "0" for No (did not live alone).**
- **Mrs. X was the** primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. **Code "0" for No (did not live alone).**
- Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. **Code "1" for Yes (lived alone).**
- Mr. M, who has been blii since birth, was admitted to the nursing home with his seeing eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. **Code "1" for Yes (lived alone).**
- **Mr. G** lived in a board-and care home. Code **"2"** (In other facility).

## 4. Zip Code of Prior Primary Residence

***Definition:*** **Prior primary residence. The community address where 'the resident last resided** prior to nursing home admission. A primary residence includes a primary -home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing home or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing home, etc.

***Process:*** Review resident's admission records and transmittal records as necessary. Ask -resident and family members as appropriate. Check with your facility's admissions office.

*Coding:* Enter one digit per box beginning with the left most box. For example, Beverly Hills, CA **90210** should be entered as:

| 9 | 0 | 2 | 1 | 0 |
|---|---|---|---|---|

**Examples**

- **Mr.** T was admitted to the nursing home from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida. Enter the zip code for Jensen Beach.
- Mrs. F was admitted to the nursing home's Alzheimer's Special Care Unit after spending 3 years living with her daughter's family in Newton, MA. Prior to moving in with her daughter, Mrs. F lived in Boston, MA for 50 years with her husband until he died. Enter the Newton, MA zip code. Rationale: Her daughter's home was Mrs. F's primary residence prior to nursing home admission.
- Ms. Q was admitted from a state psychiatric hospital in Illinois where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Kansas City, Kansas. Enter the Kansas City zip code.

## 5. Residential History 5 Years Prior to Entry

*Intent:* To document the resident's previous experience living in institutional or group settings.

*Definition:* Prior stay 'at this nursing home — Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

**Stay in** other **nursing** home — Prior stay in one or more nursing homes other **than** current facility.

Other residential facility — Examples include board and **care** home, group home, and assisted living.

**MH/psychiatric** setting — Examples **include** mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

MR/DD setting — Examples include mental retardation 'or developmental disabilities facility (including MR/DD institutions), intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

***Process:*** Review the admission record. Consult the resident or family. Consult the resident's physician.

***Coding:*** Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1.). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e., the place the resident called "home" at that time). If the resident has not lived in any of these settings in the past five years, check NONE ***OF ABOVE,***

## 6. Lifetime Occupation

***Intent:*** To identify the resident's role or past role 'in life and to establish familiarity in how staff should address the resident. For example, a physician **might** appreciate being referred to as "Doctor". Knowing a person's lifetime occupation is also helpful for care-planning purposes. For example, a carpenter might enjoy pursuing hobby shop activities.

***Coding:*** Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box.

The lifetime occupation of a person whose primary work was in the home should be recorded as "Homemaker." When two ***occupations are identified, place a slash (/) between each occupation.*** A person who had two careers (e.g., carpenter and night watchman) should be recorded as "Carpenter/Night Watchman". ***For a resident who is a child or an MR/DD adult resident who has never been employed, record as "NONE."***

## 7. Education (Highest Level Completed)

***Intent:*** To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g., interpreting cognitive patterns or language skills), care planning (e.g., deciding how to focus a planned activity program), and planning for resident education in self-care skills.

***Definition:*** The highest level of education attained.

**Technical or Trade School:** Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

**Some College:** Includes completion of some college courses, junior (commumty) college, or associate's degree.

**Bachelor's degree:** Includes any undergraduate bachelor's level college degree.

**Graduate Degree:** Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

**Process:** Ask the resident and significant other(s). Review the resident% record.

***Coding:*** Code for the best response. For MR/DD residents who have received special education services, code "2" (8th grade/less).

## 8. Language

***Definition:*** **a. Primary language — The** language the resident primarily speaks or understands.

***Process:*** Interview the resident and family. Observe and listen. Review the clinical record.

***Coding:*** Enter **"0"** for English, "1" for Spanish, "2" for French, "3" for Other. If the resident's primary language is not listed, code "3" for Other and print the resident's primary language in item 8b beginning with the left most box.

**Example**

Mrs. F emigrated with **her** family from East Africa several years ago. She is able to speak and understand very little English. She depends on her family to translate informationin Swahili.

a. Primary Language — "3" Other

b. If other, specify

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| S | W | A | H | I | L | I | | |

## 9. Mental Health History

*Intent:* To document a primary or secondary diagnosis of psychiatric illness **or** developmental disability.

***Definition:*** Resident has one of the following:

- A schizophrenic, mood, paranoid; panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; **or** another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of'dementia, including Akheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or **(b)** within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcementofficials.

***Process:*** Review the resident's record only. For a "Yes" response to be entered, there must be written documentation (i.e., verbal reports from the resident or resident's family are not suffkient).

***Coding:*** Enter "1" for Yes or "0" for No.

## 10. Conditions Related to MR/DD Status (Mental Retardation/ Developmental Disabilities)

*Intent:* To document conditions associated *with* mental retardation or developmental disabilities.

*Definition:* For item 10e, "Other organic condition related to MR/DD" — Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia; neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.

*Process:* Review the resident's record only. For any item (10b through 10f) to be checked, the condition must be documented in the clinical record.

*Coding:* Check all conditions related to MR/DD status that were present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

- If an MR/DD condition is not present, check item 10a ("Not Applicable — No MR/DD") and skip to item AB-1 1.
- If an MR/DD condition is present, check each condition that applies.
- If an MR/DD condition is present but the resident does not have any of the specific conditions listed, check item 10f ("MR/DD with No Organic Condition").

## 11. Date Background Information Complete

*Intent:* For tracking purposes, this item should reflect the date that the ***Background (Face Sheet) Information At Admission*** form is completed or amended.

*Coding:* Enter the date the ***Background (Face Sheet) Infornmtion At Admission*** form is originally completed. In some circumstances (e.g., if a knowledgeable family member is not available during the M-day assessment period), it is difficult to fill in all the background information requested on this form. However, the information is often obtained at a later date. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item (AB 11) should then reflect the date that new information is recorded or existing information is revised.

Examples

Mr. B was admitted to your facility on 12/3/94 in a comatose state and therefore, unable to communicate in his own behalf. By reviewing transmittal records that accompanied him from the acute care hospital, you find that you are only able to partially complete Section Al3 (Demographic Information), and you are unable to complete Section AC (Customary Routine) because the records are scanty in these areas. You decide to complete what you can by the 14th day of Mr. B's residency (the date the MDS assessment is to be completed) and enter the date 12/17/94 for item' AB 11. On 12/24/94 Mr. B's only relative, a daughter, visits and you are able to obtain more information from her. Enter the new information (e.g., demographic or customary routines) on the form and then enter the date 12/24/94 for item AB 11.

# AC. CUSTOMARY ROUTINE

## 1. Customary Routine (In the year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)

***Intent:*** These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (AB1) to your nursing home. If the resident is being admitted from another nursing home, review the resident's routine during the last year the resident lived in the community. The items should initiate a flow of information about cognitive patterns, activity preferences, nutritional preferences and problems, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other. sections of the MDS that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care.

***Process:*** Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process such as described in Guidelines for Interviewing-Resident that follow. Also see in Appendix D.

If the resident cannot respond (e.g., is severely demented or aphasic), ask a family member or other representative of the resident (e.g., legal guardian). For some residents you may be unable to obtain this information (e.g., a

demented resident who first entered the facility many years ago and has no family to provide accurate information)

Guidelines for Interviewing Resident

Staff should regard this step in the assessment process as a good time to get to know the resident as an individual and an opportunity to set a positive tone for the future relationship. It is also a useful starting point for building trust prior to asking difficul questions about urinary incontinence, advance directives, etc.

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the resident at ease. Explain at the outse why you are asking these questions ("Staff want to know more about you so you car have a comfortable stay with us." "These are things that many older people find important." "I'm going to ask a little bit about how you usually spend your day.")

Begin with a general question — e.g., "Tell me, how did you spend a typical day before coming here (or before going to the first nursing facility)?" or "What were some of the things you liked to do?" Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and leisure activities involvements. As the resident becomes engaged in the discussion, probe for informatior on each item of the Customary Routine section (i.e., cycle of daily events, eating patterns, ADL patterns, involvement patterns). Realize, however, that a resident whc has been in an institutional setting for many years prior to coming to your facility may no longer be able to give an accurate description of pre-institutional routines. Some residents will persist in describing their experience in the long-term care setting, and will need to be reminded by the interviewer to focus on their usual routines prior tc admission. Ask the resident, "Is this what you did **before** you came to live here?"

If the resident has difficulty responding to prompts regarding particular items, backtrack by reexplaining that you are asking these questions to help you 'understand how the resident's usual day was spent and how certain things were done. It may be necessary to ask a number of open-ended questions in order to obtain the necessary information Prompts should be highly individualized.

Walk the resident through atypical day. Focus on usual habits, involvement with others! and activities. Phrase questions in the past tense. Periodically reiterate to the resident that you are interested in the resident's routine before nursing home admission, and thar you want to know what he or she actually did, not what he or she might like to do.

(continued **on next page)**

**Guidelines for Interviewing Resident (continued)**

For example:

After you retired from your job, did you get up at a regular time in the morning?
When did you usually get up in the morning?
What was the first thing you did after you arose?
What time did you usually have breakfast?
What kind of food did you like for breakfast?
What happened after breakfast? (Probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
When did you have lunch? Was it usually a big meal or just a snack?
What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
Did you ever have a drink before dinner? Every day? Weekly?
What time did you usually bathe? Did you usually take a shower or a tub bath?
How often did you bathe? Did you prefer AM or PM?
Did you snack in the evening?
What time did ***you usually go*** **to bed?** Did you usually wake up during the night?

***Definition:*** **Goes out 1+ days a week** — Went outside for any reason (e.g., socialization, fresh air, clinic visit).

**Use of tobacco products at least daiiy — Smoked any type of tobacco (e.g., cigarettes, cigars, pipe) at least once daily. This item also includes sniffmg or chewing tobacco.**

**Distinct food preferences — This** item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread). ***Do not check this item for simple likes and dislikes.***

**Use of alcoholic beverage(s) at least weekly** — Drank at least one alcoholic drink per week.

Wakens **to toilet all or most nights** — Awoke to use the toilet at least once during the night all or most of the time.

Has **irregular bowel movement pattern** — Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

Bathing in **PM** — Took shower or bath in the evening.

Daily contact **with** relatives/close friends — Includes visits and telephone calls. Does not include exchange of letters only.

Usually attends church, temple, synagogue (etc.) — Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

Daily animal companion/presence — Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

**Unknown** — If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check the last box in the category ("UNKNOWN"), leave all other boxes in Section AB blank.

***Coding:*** Coding is liited to selected routines in the year prior to the resident's first admission to a nursing facility. ***Code the resident's actual routine rather than his or her goals or preferences (e.g., if the*** resident would have liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/close friends").

Under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a ***NONE OF ABOVE*** choice is available. For example, if the resident did not engage in any of the items listed under Cycle of Daily Events, indicate this by checking ***NONE*** OF ***ABOVE*** for Cycle of Daily Events.

If an individual item in a particular category is not known (e.g."Finds strength in faith," under Involvement Patterns), enter "NA" or a circled dash.

If information is unavailable for all the items in the entire Customary Routine section, check the final box "UNKNOWN" — Resident/family unable to provide information". If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

# AD. FACE SHEET SIGNATURES

## a. Signature of RN Assessment Coordinator

*Coding:* The RN Assessment Coordinator who worked on the ***Background (Face Sheet) Information at Admission sections*** of the MDS must enter his or her signature on the day this part of the MDS form is complete. Also, to the right of the name enter the date the form was signed.

## b-g. Signature of Others Who Completed Part of Background Assessment Sections AB and AC

*Coding:* Other staff who completed parts of the Background sections of the MDS must enter their signature, the sections they completed, and the date they completed their assigned sections.

# MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENI-NG (MDS)

# FUNCTIONAL ASSESSMENT

## Sections A – R

# SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

### 1. Resident Name

*De finition:* Legal name in record.

*Coding:* Print the resident's name in the following order — a.) first name, b.) middle initial, c.) last name, d.) Jr./Sr. If the resident goes by his or her middle name, enter the full middle name. If the resident'has no middle initial, leave item (b) blank.

### 2. Room Number

*Inten t:* Another identifying number for tracking purposes.

*Definition:* The number of resident's room in the facility.

*Coding:* **Start in the left most box, use as many boxes as needed.**

**Example**

Mr. F lives in Room N305 at your facility. The N stands for New Building in your

| | | | | |
|---|---|---|---|---|
| N | 3 | 0 | 5 | |

two building complex. The three hundred series of rooms are on the third floor.

## 3. Assessment Reference Date

*Intent:* To establish a common temporal reference point for all staff participating in the resident's assessment. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period (i.e., "starting the clock" so that all assessment items refer to the resident's objective performance and health status during the same period of time).

*Definition:* **a. Last day of MDS observation period. This** date refers to a specific endpoint in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period, most frequently the seven day period ending on this date. The date sets the designated endpoint of the common observation period, and all MDS items refer back in time from this point. Some cover the 14 days ending on this day, some 30 days ending on this date; and so forth.

*Coding:* The first coding task is to enter the observation reference date (i.e., the end point date of the observation period). For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for completing the admission assessment). For a followup assessment, select a common reference date within the period the assessment must be completed. Thii date is the endpoint to which all MDS items must refer.

For an admission assessment, staff may begin to gather some information on the day of admission. An observation end date will be set, often a date prior to day 14.

**RAPs must be completed within regulatory required time frames for completion of the RAI.**

**Examples of** Assessment Reference Date **for an Admission Assessment**

Mrs. M was admitted to your facility on 8/20/94. Your facility's policy states that all MDS assessments for new admissions shall be completed by the 7th day of residency. Therefore, staff decided to conduct their observations, tests, interviews with resident, family and other staff, and chart reviews during the first 7 days of the resident's stay. -During this time they record pertinent findings in the resident's record and, where appropriate, on the MDS form. They record the endpoint of the' MDS observation period as follows, giving staff another 7 days in which to complete the RAPs:

| 0 | 8 | | 2 | 6 | | 1 | 9 | 9 | 4 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

Mr. S was admitted to your facility on 8/20/94. Your facility's policy states that all MDS assessments for new admissions shall be completed by the 14th day of residency. The interdisciplinary team on the new resident's unit decides to take the full 14 days to complete the assessment. Of course they conduct observations, tests, necessary interviews, and chart reviews necessary for care planning. During this time they record pertinent findings in the resident's record. They record the endpoint of the MDS observation period as follows, with the stipulation that the RAPs must also be completed on that date:

| 0 | 9 | | 0 | 2 | | 1 | 9 | 9 | 4 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | D a y | | | Year | | | |

**Rationale: As 9/2/94 is the** 14th day of residency, the period of review for the MDS items will be the 7 days prior to that date, plus the period that ends on that date (or the period from 8/27 through 9/2/94).

For an annual assessment, staff are likely to have extensive data on hand. In such cases, a designated observation period of seven days is usually established. The date on which the observation period ends is the Assessment Reference Date. All staff who participate in the assessment must, however, agree that their description of the resident reflects the resident's status in this seven day period.

For the month and day of the assessment, enter two digits each, using zero, ("0") as a filler. Use four digits for the year.

## 5. Marital Status

*Coding:* Choose the answer that describes the current marital status of the resident.

## 6. Medical Record Number

*Definition:* This number is the unique identifier assigned by the facility for the resident. Get it from the facility's admissions office, business office, or medical records department.

## 7. Current Payment Source(s) for Nursing Home Stay

*Intent:* To determine payment source(s) that cover the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days.

*Definition:* Per diem — Room, board, musing care, activities, and services included in the routine daily charge.

**Ancillary** — Services such as medications, equipment. for treatments, or supplies billed outside of the daily routine per diem charge.

Self (or famiiy) pays — full — Includes full private pay by resident or family.

Self **(or' family) pays — co-pay** — The resident is responsible for a co-payment.

Private insurance — The resident's private insurance company is covering daily charges.

Other — Examples include Commission for the Blind, Alzheimer's Association.

*Process:* Check with the billing office to review current payment sources. Do not rely exclusively on information recorded in the resident's, clinical record, as the resident's clinical condition may trigger different sources of payment over time. Usually business offices track such information.

*Coding:* For each payment source, check the corresponding answer box.

Example of Current Payment Sources

Mr. F. was recently admitted to your facility from an acute care hospital. Medicare (Part A) has partially covered his per diem and ancillary services, and private insurance has covered the remainder of his charges. Mr. F. does not belong to a managed' care program.

Check "b", Medicare per diem, "c", Medicare ancillary, and "i", Private insurance.

## 8. Reasons for Assessment

### a. Primary Reason for Assessment

*Intent:* To document the key reason for completing the assessment, using the various categories of assessment types mandated by **Federal** regulation. Most of the types of assessments listed below will require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI. [Note — assessment type 5 requires you to complete only a limited number of MDS items.] Please note that it is possible to select a code from both 8a (Primary reason for assessment) and 8b (Special codes).

***Minimum Discharge Assessment Requirement.*** With the release of Version 2.0 of the MDS, a minimal list of MDS items must be completed for all discharges and facility reentries. These items are referenced on their own forms and item 8 also appears on these forms — it is listed as Item 8 in Section AA of the &charge ***Tracking and Reentry Tracking Forms;*** it is also Item AA8 on the ***Basic Assessment Tracking Form.***

*Definition:*

1. **Admission assessment.** A comprehensive assessment using the MDS and RAPs required by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.

2. **Annual assessment — A** comprehensive reassessment required within 12 months of the most recent full assessment. If significant change is noted, code **"3"** (significant change in status assessment). DO NOT code as an Annual assessment.

3. Significant change in status assessment — A comprehensive reassessment prompted by a "major change" that is not self-Iimited, that impacts on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan to ensure that

appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. See procedure described below for assessing whether a significant change (either improvement or decline) has occurred.

4. Significant correction of prior assessment —A comprehensive assessment completed at the facility's prerogative, because the previous. assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which case there has been an actual change in the resident's health status.

5. Quarterly Assessment -The subset of MDS items specified on HCFA's Quarterly Assessment Form, which must be completed no less frequently than once every 3 months (Le., between required full assessments). This assessment ensures that the care plan is correct and up to date. It also should identify instances where significant changes have occurred. If significant change is noted, Code "3" (Significant change in status assessment). DO NOT CODE as Quarterly review assessment.

Minimum **Discharge** Information — Until HCFA's ADP requirement is effective, this code is used only by facilities that are already required to submit data to the State. A subset of MDS items must be completed for all residents who are discharged or are out of the facility over night. Differentiate whether return is anticipated, not anticipated, or whether the resident has been discharged prior to completing an initial assessment. These items are referenced below.

6. **Discharged — return not anticipated — [This is** not a code used on this form; it is used 'on the ***Discharge Tracking Form only.]*** Use this code whenever a resident is permanently discharged from a nursing facility. This is a means of "closing" the record of any resident at the point of discharge from the facility (without an anticipated return). Note — until **HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

7. **Discharged — return anticipated — [This is not a code used on this form;** it is used on the ***Discharge Tracking Form only.]*** Use this code when a resident is temporarily discharged to a hospital (or other therapeutic setting). Also use this code when a respite patient returns home, with an anticipated return to this facility at a later date. Note — until **HCFA's ADP** requirement is effective, this code is used only in facilities that are required to submit **data to the State.**

*8.* Discharged prior to completing initial assessment — [This is not a code used on this form; it is used on the *Discharge Tracking Form* only.] ***Use this*** code when the resident is discharged during the first ***14*** days of residency AND the **MDS** assessment remains incomplete. A subset of information is entered for all residents regardless of length of stay. ***Even a very short stay resident (e.g., a person who stayedfor even one day) must be tracked by the MDS system.*** At the same time, remember that you have 14 days to complete the full MDS admission assessment, and by using this code you are identifying residents who have been discharged, transferred or died prior to day 14, thereby prohibiting your completion of a full assessment. Note — **until HCFA's ADP** requirement is effective, this code is used only in facilities that are required to submit data to **the State.**

**Miuimum Reentry Information** — Until HCFA's ADP requirement is effective, this code is used only by facilities that are already required to submit data to the State. A subset of **MDS** items must be completed for residents "reentering" the facility after a temporary absence (other than a therapeutic leave) in order to reenter the resident into the **State** database.

**9. Reentry** — [This is not a code used on this form; it is used on the ***Reentry Tracking Form only.]*** Use this code when a resident of your facility is readmitted from a temporary discharge to a hospital or other therapeutic setting (other than for a therapeutic leave). Note — until **HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

**0. NONE OF ABOVE** — Use this code when your state requires you to complete one of the additional assessment types referenced in Item AA8 (below). It indicates that the assessment. has been completed to comply with State-specific requirements (e.g., case-mix payment). Select the code under item b (below) that indicates the primary reason for assessment.

**b. Special codes for use with supplemental assessment types in Case-Mix. Demonstration States or other States where required.** It is possible to select a code from both 8a and 8b (e.g., Item 8a coded "3" (Significant Change in Status assessment), and Item 8b coded "3" (60-day assessment).

**1. 5 day assessment** — Required for payment reasons prior to the Federally mandated admission assessment required by day 14 (Code 1, for item a).

2. 30 day assessment

3. 60 day assessment -- In following this cycle of assessments, the initial Quarterly review assessment would be due at 90 days.

4. Quarterly assessment using full MDS form -- Assessment completed within a 3-month interval from the last assessment, using a full (not quarterly) MDS assessment form as required by the State or NHCMQ demonstration.

5. Readmission/return assessment -- A full reassessment (i.e., MDS and RAPs) required only for residents in NHCMQ demonstration facilities (or as required by the State) who are hospitalized for more than 72 hours, or who are discharged and later readmitted to the facility from the hospital.

6. Other state required assessment -- An example is a Utilization Review assessment. States may issue additional instructions.

***Coding:*** Enter the number corresponding to the primary reason for assessment. For item a (Primary reason for assessment), for codes l-9, leave first box blank, placing correct digit in the second box.

Additional Comments on Significant Change Assessment

Facilities have an ongoing responsibility to assess the resident's status and intervene to assist the resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. Staff have the responsibility of deciding whether a change they have noted (either an improvement or decline) is significant.

A "significant change" is defined as a major change in the resident's status that:

- Is not self-limiting;
- Impacts on more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan.

The following indicate conditions under which a significant change reassessment is required. The terms referenced are based on items (and definitions) found in Version 2.0 of the MDS. Other situations can apply; this list is not exhaustive, and other situations may also meet significant change definition. [Note -- in an end stage disease status, a full reassessment is optional, depending on a clinical determination of whether or not the resident would benefit from the reassessment.]

A significant change may occur at any point during the resident's stay, although facilities may most commonly identify that a significant change has occurred while constructing the resident's scheduled quarterly review. Over a six-month period, depending on the resident population, one in five residents typically declines in two or more of these areas. The goal

of the significant change reassessment is to ensure that residents are being appropriately monitored and necessary changes in care instituted. Also see discussion in Chapter 2.

SIGNIFICANT CHANGE CRITERIA*

A significant change assessment is required if a decline (or improvement) change. is consistently noted in two or more areas of decline, or two or more areas of improvement.

DECLINE

- Any **decline in ADL physical functioning** where a resident is newly coded as 3, 4, or 8 (Extensive assistance; Total dependency; Activity did not occur).
- Increase in **number** of areas where Behavioral symptoms are coded as not easily altered (increase in number of code l's for E4B).
- Resident's decision making changes from 0 or 1 to 2 or 3.
- Resident's incontinence pattern changes from 0 or 1 to 2, 3, or 4, or placement of an indwelling catheter.
- Emergence of sad or anxious mood as a problem that is not easily altered.
- Emergence of an unplanned weight loss problem (5 % change in 30 days or 10 % change in 180 days)
- **Begin** to use a trunk restraint or a chair that prevents rising for **a resident when it was not used before.**
- **Emergence** of a condition/disease in which resident is judged to be unstable.
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at that stage or higher.
- Overall deterioration of resident's condition; resident receives more support, (e.g., in performing ADLs, or in decision making).

IMPROVEMENT

- Any improvement in ADL physical **functioning where a resident is newly coded as 0, 1,** or 2 when previously scored as a 3, 4, or 8.
- Decrease in number of areas where Behavioral symptoms of sad or anxious mood are coded as not easily altered.
- Resident's decision making changes from 2 or 3 to. 0 or 1.
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1.
- Overall improvement of resident's condition; resident receives fewer supports.

* **This is** not an exhaustive list.

## 9. Responsibility/Legal Guardian

*intent:* To record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending

on the resident.5 condition, multiple options may apply. For example, a resident withmoderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a resident may have executed a limited power of attorney to someone responsible only for legal affairs. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here "are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification.

***Definition:*** ***Legal*** guardian — Someone who has been appointed after a court hearing and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

**Other legal oversight** — Use this category for any other program in your State whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

Durable power **of attorney/health care** — Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

Durable power **of attorney/financial** — Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

**Family member responsible** — Includes immediate family or significant other(s) as designated by the resident, Responsibility for decision-making may be shared by both resident and family.

Patient **responsible for self** — Resident retains responsibility for decisions. In the absence.of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

***Process:*** Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by state law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

*Coding:* Check all that apply.

## 10. Advanced Directives

*Intent:* To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of preexisting directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any discrepancies between the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

*Definition:* **Living will —** A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

**Do not resuscitate —** In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

**Do not hospitalize —** A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

**Organ donation — Instructions** indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

**Autopsy request —** Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family or responsible party must still be contacted upon the resident's death and re-asked if they want an autopsy to be performed.

**Feeding restrictions — The resident or responsible party** (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

_ Medication restrictions — The resident or responsible party (family or legal guardian) does not wish the resident to receive life-sustaining medications

(e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

Other treatment restrictions — The resident or responsible'party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intnbation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

***Process:*** You will need to familiarize yourself with the legal status of each type of directive in your State. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities. should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation'must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest faniily members or, in their absence or in case of conflict, through legal guardianship proceedmgs.

***Coding:*** The following comments provide further guidance on how to code these diitives. You will also need to consider State law, legal interpretations, and facility policy.,

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.

- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding

restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.

- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

***Coding:*** Check all that apply. If none of the directives are verified by -documentation in the medical records, check NONE *OF ABOVE*.

# SECTION B.
# COGNITIVE PATTERNS

***Intent:*** To determine the resident's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors in many care-planning decisions. Your focus is on resident performance, including a demonstrated ability to remember recent and long-past events and to perform key decision making skills.

Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the questions cogently.

Be sure to interview the resident in a private, quiet area without distractions — i.e., not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust between staff and resident. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to clarify or validate inforination regarding the resident's cognitive function over the last seven days. For residents with limited communication skills or who are best understood by family or specific care givers, you will need to carefully consider their insights in this area.

- Engage the resident in general conversation to help establish rapport.

- Actively listen and observe for clues to help you structure your assessment. Remember — repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.

- Be open, supportive, and reassuring during your conversation with the resident (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

  If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, "Let's talk about something else now," or "We don't need to talk about that now. We can do it later". Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

## 1. Comatose

***Intent:*** To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

***Coding:*** Enter the appropriate number in the box.

If the resident has been diagnosed as comatose or in a persistent vegetative state, code "1". ***Skip to Section G.*** ***If the*** resident is not comatose or is semi-comatose, code "0" and proceed to the next item (B2).

## 2. Memory

***Intent:*** To determine the resident's functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory).

***Process:*** a. Short-Term Memory: Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over

time or following through on a direction given five minutes earlier) the correct response is "1", Memory Problem.

**Examples**

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1." For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number).

b. Long-Term **Memory:** Engage in conversation that is meaningful to the resident. Ask questions for which you can validate the answers (from your review of record, general knowledge, 'the resident's family). For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, the correct response is "1", Memory Problem.

**Example**

Ask the resident, "Where did you live just before you came here?" If "at home" is the reply, ask "What was your address?" If "another nursing home" is the reply, ask "What was the name of the place?" Then ask: "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

*Coding:* Enter the numbers that correspond to the observed responses.

## 3. Memory/Recall Ability

*Intent:* To determine the resident's memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition, yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

*Definition:* **Current season** — Able to identify the. current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).

**Location of own room** — Able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

Staff **names/faces** — Able to diitinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and. not the resident's son or daughter, etc.

**That he/she is in a nursing home — Able to determine that he** or she is currently living in a nursing home. To check this item, it is not-necessary that the resident be able to state the name of the facility, but he/she should be able to refer to the facility by a term such as a "home for older people", a "hospital for the elderly", "a place where older people live", etc.

*Process:* Test memory/recall. Use information obtained from clinical records or staff. Ask the resident about each item. For example, "What is the current season? "What is the name of this place?" "What is this kind of place?" If the resident is not in his or her room, ask **"Will you show me to your room?"** Observe the resident's ability to find the way.

*Coding:* For each item that the resident can recall, check the corresponding answer box. If the resident can recall none, check NONE *OF ABOVE.*

## 4. Cognitive Skills for Daily Decision-Making

*Intent:* To record the resident's actual performance in making everyday decisions about tasks or activities of daily living.

**Examples**

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately **(i.e.,** not repetitively) from others in order to plan the day; using awareness'of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

*Process:* Review the clinical record. Consult family and nurse assistants. Observe the resident. ***The inquiry should focus on whether the resident is actively making these decisions, and not whether staff believe the resident might be capable of doing so. Remember the intent of this item is to record what the resident is doing (performance).*** Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making., whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

*Coding:* Enter one number that corresponds to the most correct response.

0. Independent — The resident's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

1. Modified Independence — The resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new task or situations.

2. Moderately Impaired — The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

3. Severely Impaired — The resident's decision-making was severely impaired; the resident never (or rarely) made decisions.

## 5. Indicators of Delirium — Periodic Disordered Thinking/Awareness

*Intent:* To record behavioral signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by **rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.**

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a **pre-existing** cognitive impairment or **pre-existing** behaviors such as restlessness, calling out, etc., detecting signs of deliiium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to fmd his or her way around **the** unit may begin to get Yost".

***Definitions:*** a. Easily distracted (e.g., difficulty paying attention; gets sidetracked)

b. Periods of altered **perception** or **awareness** of surroundings (e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. Episodes of disorganized **speech** (e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses tram of thought)

d. Periods of restlessness (e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)

**e.** Periods of lethargy (e.g., sluggishness, staring into space; **difficult** to arouse; little body movement)

**f.** Mental function **varies over the course of the day (e.g., sometimes** better, sometimes worse; behaviors sometimes present, sometimes not)

***Coding:*** ***Code*** for resident's behavior in the last seven days regardless of what you believe the cause to be — focusing on when the manifested behavior first occurred.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)